JANUARY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

TOWARDS NEW INTERNATIONAL SANITARY REGULATIONS

MALARIA IN EUROPE

INFLUENZA IN EUROPE

EASTERN MEDITERRANEAN CONFERENCE

SEROLOGY OF SYPHILIS

PENICILLIN IN VENEREAL DISEASES

WORLD HEALTH ORGANIZATION

PALAIS DES NATIONS

GENEVA

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

TOWARDS NEW INTERNATIONAL SANITARY REGULATIONS

First session of the Expert Committee on International Epidemiology and Quarantine

International health regulations will be needed until the true objective of international epidemic control — the eradication of pestilential diseases — has been achieved This emerged clearly from discussions held during the first session of the Expert Committee on International Epidemiology and Quarantine entrusted by the first Health Assembly with the study of the best means of relieving public health administrations from the constant menace of epidemic outbreaks of smallpox and typhus and over large areas of the world of cholera plague and yellow fever

The present expert committee continues the work of two expert committees of the Interim Commission — the Expert Committee on International Epidemic Control and the Expert Committee on Quarantine The former committee which had met in Geneva in April 1948 had agreed among many other things that protective measures taken by countries at their respective borders under existing international sanitary conventions were palliatives as effective international control of epidemics required delimitation of endemic areas and recommended an attack on the endemic foci with the technical help of WHO if needed [1]

The new committee [2] some members of which had already served on the two committees of the Interim Commission met in Geneva from

Off R W ld Hl h Org 11 21 see also *Ch on W ld Hl h O g* 1948 2, 145

Prese t t thi session

P ofesseu A R D jarric d la Riviere, Sous-Directeu de l'I stit Paste Paris, F ance

D G L D nahoo Medical Directo Ch ef Fore gn Qu rantine Division, US Publ H alth Service W shi gton, D C USA

D H S Ge Deputy Chief Health Officer for the Union f South Africa, Cape T wn, Union of South Africa

D G D H mmes, Inspecto of Public Heal h, Utrecht, N therl nds [Con inued on p 7]

15–20 November 1948 Having unanimously agreed that defensive measures against pestilential diseases will still be needed for some time the committee set as its main task the definition of the principles on which WHO sanitary regulations should be established It will be recalled[3] that these are intended to replace the present international sanitary conventions which are held to be awkward and obsolete in many respects

Basic Principles

The committee agreed that it was desirable that the regulations should be prefaced by a preamble showing the respective responsibilities of governments and of WHO in the international control of epidemic diseases Dr Dujarric de la Riviere was entrusted with the task of writing the preamble, together with a commentary on the proposed principles

The preamble would outline the essential principles on which the actual articles of the regulations had been based, and in particular emphasize that

(*a*) accurate and rapid notifications were the basis of effective measures against the international spread of disease and of the withdrawal of restrictions on international traffic as soon as danger of infection had ceased,

(*b*) each country should develop its internal resistance to disease rather than rely on measures taken at its frontiers For instance proper sanitation country wide immunization and freedom from insect vectors would effectively prevent epidemics of cholera smallpox typhus fever etc should such infections be introduced through evasion of the frontier quarantine control,

(*c*) measures taken at frontiers should be the minimum compatible with the existing sanitary situation Excessive measures not only entailed undue interference with traffic and severe economic consequences but might by their very excess, lead to deliberate evasion of the sanitary control and thereby defeat their object The committee emphasized the principle that the measures to be specified in the WHO regulations should not be exceeded by health administrations It would therefore be necessary to specify the maximum measures applicable in exceptional as well as in normal circumstances

Dr Melville Mackenzie Principal Medical Officer Ministry of Health, London, United Kingdom
Dr C. Mani Deputy Director General of Health Services, New Delhi India
Dr M Nazif Bey Under Secretary of State for Quarantine Ministry of Public Health Cairo, Egypt
Professor O H de Paula Souza Director Faculty of Hygiene and Public Health, University of São Paulo Brazil
Dr W W Yung, Chief Medical Officer Ministry of Health, Nanking, China

Ex officio members
Dr M Gaud, Rapporteur of the Joint OIHP/WHO Study-Groups
Dr A M Macchiavello representing the Director of the Pan American Sanitary Bureau
Dr M T Morgan Président du Comité permanent de l'Office International d'Hygiène Publique
Dr F L. de Talèl, representing the International Civil Aviation Organization.

Secretariat
Dr Y M Biraud, Director Division of Epidemiology WHO Secretary of the Committee
Dr G Stuart, Chief Sanitary Conventions and Quarantine Section, WHO

[3] *Chron. World Hlth Org.* 1947 1 1—

Epidemiological Notification and Information

The system of present and future defence against epidemics rests on prompt information of any outbreak and the committee stressed the need for every country to send immediate notification to the nearest WHO regional epidemiological information station and to the WHO world centre and when possible to neighbouring countries

This is not enough however as increased speed of traffic necessitates an increased speed of epidemiological information The committee therefore approved a proposal made by the Secretariat to initiate on an experimental basis a daily radio telegraphic broadcast of an epidemiological bulletin by WHO at Geneva thus extending a system which had proved its practical value in the zone served by the Singapore Epidemiological Station The radio bulletin would include information about pestilential diseases in sea and airports as well as new quarantine and immunization requirements The bulletins consisting of 200 to 300 words would be broadcast on long wave to cover Europe and on short wave in three beams to cover the other continents National health administrations would give instructions to the telegraphic authorities in their countries to pick up the bulletins and distribute them by multiple address telegrams to selected port and sanitary authorities This would ensure cheap rapid and effective dissemination of the epidemiological information collected.

The establishment of this new system need not it was decided await the coming into-force of the new regulations but could be applied forthwith as an experimental measure concurrently with the system of notification now in force

Definition of Local Areas as a Basis for Notifications and Measures

Notifications should be made only in respect of and measures should be taken solely against arrivals from distinct units (administrative or sanitary) which could be described as local areas [4] Only when no definition of the infected area is available should restrictive measures be applied against the whole national territory

Identification of infected local areas will be facilitated by the list of administrative districts of the various countries which will be included in the new epidemiological code now being prepared by the WHO Secretariat (*Codepid*) and grid maps for localization of infection within provinces and districts

[4] According to the definition contained in the first chapter (Article 8) of the International Sanitary Convention, 1903 which provides that the words local areas denote well-defined areas, such as province, a government, district, a department, canton, island commune, a town, quarter of a town, village, a port, a polder an agglomeration etc., whatever may be the extent and population of such areas."

Adaptation of Measures to Degree of Infection

The rule provided by the present conventions [5] that measures should not be taken against sea or airports in which only imported cases had occurred, will continue in the new international regulations

The following degrees of infection should be recognized in the WHO regulations (*a*) an initial case, (*b*) a "foyer", (*c*) an epidemic A 'foyer' is characterized by the occurrence of secondary cases around an initial case, an epidemic by an extension and/or multiplication of the "foyer"

International sanitary measures permissible against an infected local area should depend upon the degree of infection and upon the efficacy of the control measures applied to the outbreak by the health authorities of the infected country Such efficacy could be judged objectively only on the basis of prompt and accurate notification from the infected local area as to the number and distribution of cases showing the development or regression of the outbreak

Cessation of Danger of Infection

One of the recognized shortcomings of the present international sanitary conventions is that judgement on the cessation of danger of infection is left with the sanitary authorities of the infected area While it is universally agreed that measures should not be taken against an infected area or country longer than the danger of transmission persists there is seldom unanimity on the duration of the danger

An attempt will be made in the new regulations to overcome this difficulty and it was proposed that a country should be given the right to notify the cessation of danger when preventive measures had been carried out without interruption intensively and successfully and in addition a period of x days had elapsed, counted from the date of isolation, death or recovery of the last case

It was agreed that the period of *x* days should be based on the period of incubation of the disease plus a period of security, intended to cover possible delay in diagnosing a case and the lag between the recognition and notification of the said cases (The security period might for instance be equal to twice the period of incubation)

It is important to note that cessation of danger of infection could only be notified at the end of an epidemic in an area normally free from infection but not in an area where disease remained endemic and where in consequence danger of infection persisted

[5] Article 10 International Sanitary Convention 1926, amended by the International Sanitary Convention 1944

Can this new definition be expected to put an end to the controversies which have arisen under the present conventions among the various health administrations? While it may reasonably be hoped that in most cases there will be general agreement the possibility of occasional diver gencies of opinion will still exist and the committee deemed it necessary to investigate means of arbitration

The first Health Assembly had already decided that WHO experts could act as arbitrators after a visit on the spot such arbitration could take place if a country complained that another country continued to impose restrictive measures against it and therefore invited WHO to send an expert ob erver to the area in question It was believed that infected countries would realize the advantages to be gained from the presence of such an observer it would help greatly in allaying unfounded fears concerning the epidemic situation thus preventing exces ive measures from being taken by other countries and enabling WHO to announce without unnecessary delay the cessation of danger of infection

The committee agreed however that no mention of observers should be included in WHO sanitary regulations and stressed that at present only moral pressure could be applied to persuade countries to give up sanitary measures exceeding the provisions of the sanitary conventions but suggested that such cases might be brought formally to the attention of the Health Assembly

Adaptation of Measures to Degree of Susceptibility of Countries to Infection

Another notable improvement on the present conventions was the proposal that countries should be encouraged to reduce or even suppress measures against the importation of certain diseases when their territory was not infectible owing to absence of insect vectors immunization of the entire population etc This follows naturally from the now generally recognized principle that the national health administrations should develop their state of defence against epidemic diseases rather than rely on restrictive measures at their borders or on measures taken by other countries

Immunization and Immunization Certificate Requirements

The medical profession cannot have failed to note that there has deve loped since the last war a widespread tendency on the part of governments to require from travellers certificates of immunization irrespective of the value of such immunization for the protection of the countries reached by travellers or for that of travellers themselves The expert committee was aware of the many disadvantages inherent in the compulsory production of immunization certificates and considered that the serious obstruction to free and rapid travel caused by such requirement was out of proportion

to the protection likely to be afforded to the country of arrival It was therefore decided that certificates of immunization against plague and against typhus should not be required from travellers, even if coming from areas infected with those diseases This represents another notable simplification as certificates of immunization against typhus are specifically recommended under the present conventions and as certificates of immunization against plague are often requested by certain countries although there is no provision to that effect in the conventions

As to the inoculations against cholera the committee decided that while being of value to the individual for his protection in an infected area they have comparatively little value as a quarantine measure to prevent the entry of the disease into a cholera free country It was accordingly agreed that WHO regulations should not oblige countries ordinarily to require incoming travellers to submit to inoculation against cholera or to produce anti cholera inoculation certificates Regulations should, however, make it permissible for countries to require such certificates from travellers coming from infected local areas It is interesting to note that, in the opinion of experts, there were reasons to believe that immunity induced by cholera inoculation lasted at least six months, and that there were experimental indications that even greater protection might be expected from Sokhey s vaccine now in the course of field trial

Measures relating to Merchandise and Baggage

Merchandise coming from an infected area should not be subjected to sanitary measures as already provided by the present conventions unless exposed to infection and suspected of being contaminated by infectious material or of harbouring reservoirs or vectors of disease With regard to cholera, it was agreed that contamination had to be of recent date to constitute a danger

The committee considered that further study should be made to determine whether a special chapter of WHO sanitary regulations should eventually be drafted to cover measures now left with each government applicable to merchandise for the prevention of non pestilential diseases such as anthrax psittacosis etc

Veterinary authorities will be consulted to decide whether WHO regulations should cover the sanitary requirements of transport of live animals capable of harbouring or of transmitting diseases communicable to man (rabies, psittacosis brucellosis tuberculosis Q fever etc) This represents another innovation in the sanitary regulations

Finally, it was agreed that the personal baggage of travellers should not be subjected to sanitary measures unless the traveller himself was suffering from one of the pestilential diseases or infested with vectors of such diseases No sanitary measures should be applied to mail The same

exemption should normally be extended to parcel post provided it did not contain articles likely to be contaminated such articles to be specified in the case of each epidemic disease

Transit Passengers at Airports

An attempt was made to alleviate quarantine measures in this respect which are known to have hampered to some extent in the past the international system of air travel Thus the expert committee agreed that no restrictive sanitary measures or immunization requirements were to be applied to passengers in transit at an airport provided they were not suffering from a communicable disease and did not leave the precincts of the airport This measure if accepted would represent a significant departure from the letter of the present conventions

Disinsectization of Aircraft

Disinsectization of aircraft is prescribed by the present conventions but a selection of the methods and insecticides to be used is left entirely with the governments concerned Continuance of such freedom was deemed unwise by the expert committee now that extensive knowledge had been gained on DDT and other similar insecticides and it was decided that methods and insecticides to be used for the disinsectization of aircraft engaged in international traffic should be prescribed in WHO regulations

Drafting of New Regulations

It will be seen that the expert committee was guided in its work by a desire to alleviate and simplify the quarantine restrictions to the farthest possible extent compatible with the security which must be ensured to every country The preamble to and commentary on the basic principles prepared by Dr Dujarric de la Riviere will be submitted by correspondence to the members of the expert committee for amendments and observations The text incorporating such amendments will then be submitted to the Executive Board and if approved to the Health Assembly The approval of those principles by the Assembly would make it possible for the Secretariat to draw up the actual draft text of WHO regulations This draft text would be discussed again by the committee at a later session and as modified would be submitted to governments prior to its final adoption by the Health Assembly

Meeting of the Quarantine Section of the Expert Committee

The expert committee appointed as members of its Section on Quarantine Dr Dunnahoo Dr Gear Dr Mackenzie Dr Nazif Bey and Dr Yung together with Dr Morgan as ex officio member The powers entrusted to

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the committee by the Executive Board as regards the interpretation and administration of existing sanitary conventions were delegated to this section The expert committee informed the quarantine section that according to the type of infringement of existing conventions cases would be dealt with (*a*) by the Secretariat, acting on its own initiative and keeping a look out for such infringements (*b*) by correspondence between the Secretariat and the members of the Section on Quarantine (*c*) by the Section on Quarantine in session (*d*) by the expert committee itself in plenary session

The Section on Quarantine met on 18 November and discussed among other things, complaints by the Government of India against other countries imposing measures in excess of the sanitary conventions, the fumigation of ships with loaded holds, the period of validity of certificates of immunization against smallpox, cholera and yellow fever the authentication of certificates and the time required for the development of effective immunity following inoculation with yellow fever vaccine The report of the expert committee and of the quarantine section will be published in a forthcoming volume of the *Official Records of the World Health Organization*

MALARIA IN EUROPE, 1938-1947

The incidence of malaria, like that of other infectious diseases[1] has undergone a great change as a result of the war Dr E J Pampana draws attention to this fact in an article which has just been published in the *Epidemiological and Vital Statistics Report* (Vol I No 18 p 392) The principal factors contributing to the spread of malaria in Europe have been the mass migrations of people soil disturbance by bombardments, floods and the destruction of sanitary engineering works a decrease in the number of livestock, resulting in the increased attraction to man of anophelines which are normally attracted to animals the disruption of public health services and the scarcity of drugs and larvicides The disease has appeared sporadically in various countries from which it had practically disappeared such as Austria France Ireland Norway Switzerland and the United Kingdom Moreover renewed outbreaks have occurred in endemic areas and malaria has spread to regions where it was formerly unknown

The displacement and transfer of populations and the return to Europe of troops from malarious countries were largely responsible for the spread of the infection and for an increase in its incidence in the following ways

— by bringing into malarious regions non immunized persons arriving from regions free from malaria

[1] See *Chron World Hlth Org* 1948 2 478

— by bringing parasite-carriers into regions free from malaria but in which anophelines capable of spreading the disease are to be found

— by bringing into a malarious region persons suffering from malaria carriers of parasitic strains differing from the local species and against which the indigenous population is not immunized

Statistical data on malaria incidence among civilians during the war and in the post war period make it possible to follow its development in the various countries of Europe Such data must however be considered approximate as many cases are not reported especially in rural areas even in countries where the notification of malaria is compulsory

In Scandinavian countries only Finland reported numerous cases of malaria particularly among troops stationed in Karelia the source of infection probably being the Russian troops at the front

In the United Kingdom in spite of the large number of hospitalized soldiers suffering from malaria the disease has not spread

In Belgium where floods caused by the occupying authorities created conditions favourable for the breeding of anophelines the disease which had been dormant for years did not reappear

In the Netherlands on the other hand in the provinces of Friesland and North Holland where malaria was present before the war there was a marked increase in the number of cases Approximately 8 500 cases were reported in 1946 some of which were probably not indigenous

In Germany as a result of the return of soldiers and prisoners suffering from malaria a few hundred indigenous cases were reported in various parts of the country especially after the end of the war In Berlin 220 local cases had been reported up to July 1946 These cases can no doubt be attributed to *Anopheles messeae* which now breeds among the ruins in the centre of the city In Eastern Friesland the only endemic focus of infection in Germany malaria decreased gradually during the war whereas the reverse occurred in the endemic foci in the Netherlands The number of cases dropped from 327 in 1938 to six in 1945

In Poland which had been the scene of serious malaria epidemics after the first World War from 250 to 300 cases only were reported annually between 1933 and 1939 But from 1940 onward the number of cases gradually increased reaching in 1946 a total of 14 000 — which figure probably does not give a true picture of the situation — in endemic foci spread over most provinces even in regions where the disease had never before been reported A control campaign was inaugurated and in 1947 the number of cases amounted to 60% of those reported in the previous year

In Czechoslovakia malaria — caused by *Plasmodium vivax* and *P falciparum* — is present in a noticeable degree only in Slovakia so that the disease again became an important problem on the re-constitution of the country

In Hungary, the malaria morbidity rate throughout the country including temporarily annexed territories increased between 1938 and 1944 From 1945 to 1947, new foci appeared in regions which up to then had been largely free from the disease This country provides an obvious example of an increase in malaria due to the influx of infected persons into regions of anophelism free from malaria and to the entry into malarious regions of persons carrying parasitic strains differing from the local varieties

The countries of southern Europe are all malarious to a greater extent than the countries mentioned above

In Italy, the number of cases of malaria — endemic and epidemic — increased from 55,000 in 1939 to 470 000 in 1945 The mortality rate however, did not keep pace with these figures This fact may be attributed to the greater efficacy of therapeutic measures The decrease in the number of cases in 1946 follows the DDT campaign begun that year in many malarious regions of Italy

In Spain and Portugal an increase in the number of cases has been noted which cannot be directly attributed to the war and the origin of which remains unexplained

In Greece, where notification of cases is not compulsory, few data are available Malaria incidence from 1941 to 1944 was approximately the same as for the years before antimalarial services were created in 1937 The disorganization of these services by the war followed by famine contributed to a fresh outbreak of the disease which reached its peak in 1942 At the beginning of 1946, DDT was applied in a large part of the country and the morbidity rate was reduced to the lowest figure yet achieved

In Bulgaria, the malaria morbidity rate decreased from 1942 onward Approximately 150 000 cases were reported in 1946

In Roumania, a decrease in the morbidity rate beginning in 1943 has also been noted Following an extensive control campaign the mortality rate dropped in certain highly infested districts from 105 per 100 000 inhabitants in 1945 to 23 per 100 000 in 1947

During the second World War, malaria spread over Yugoslavia reaching a peak in 1941 when the disease appeared in regions which had been free up to that time In 1945 and 1946 mass movements of populations caused epidemics in certain areas Antimalarial services were reorganized in 1947, and the use of DDT was followed by a decrease in the morbidity rate

The various reports emanating from European countries analysed by Dr Pampana in his article, lead to the conclusion that renewed outbreaks of malaria after the second World War have been less serious than after the first World War The application of DDT in numerous endemic regions particularly in Italy and Greece together with the use of new synthetic drugs might explain, at least in part this sequence of events The success of vector eradication campaigns carried out against *A gambiae* in Brazil

and Egypt [2] has shown that the complete eradication of a species of insect is possible even from vast territories Analogous experiments are at present being carried out in Sardinia and Cyprus Measures which have been taken up to now and the favourable results obtained make it possible to foresee the day when Europe will be free from malaria

Chron. World Hlth Org 1948 2, 85

INFLUENZA IN EUROPE

The first indication that influenza had become unduly prevalent appeared in Sardinia in October when in the course of a few days about half of the island s population was attacked By November the disease had reached the mainland of Italy and the island of Sicily By the end of that month half of the population of Rome had been affected while other towns especially Venice Verona Milan Pisa Pescara Palermo and Catania had been seriously involved. The clinical character of the disease was ordinarily mild — serious cases sometimes proving fatal being observed only in old people

In December the disease made its appearance in France During the first week of January the eastern and northern provinces were mainly affected but by the end of the second week practically all the country had become involved in an epidemic from which one fifth of the population suffered The disease was ordinarily of a mild variety but provided never theless a certain number of serious even fatal cases particularly among young children and old people

On 7 January WHO made a telegraphic inquiry of a majority of European countries as to the situation and replies received between 8 and 18 January gave the following information

Austria several thousand cases mainly in Vorarlberg and Tyrol

Greece and *Poland* sporadic cases of a mild character

Switzerland 13 cantons affected, particularly Basle City Geneva Schaff house and Tessin

Denmark Finland Norway Sweden the *American Zone of Germany Spain Portugal Ireland Albania Hungary* and *Turkey* no epidemic only a number of sporadic cases

United Kingdom no epidemic prevalence reported anywhere only a number of usual cases in London

Bulgaria influenza in mild form since mid December attacking mostly young children and persons over 60 the disease seems to follow a fairly prolonged course

Netherlands epidemic in the southern part of the country but relatively infrequent in the north

Action taken by WHO

Since the beginning of the epidemic, the special influenza laboratory of the Medical Research Council, Hampstead London acting as the World Influenza Centre of WHO, has been engaged in identifying the causal virus or viruses from throat washings obtained from cases in Great Britain France and Italy

It may be recalled that plans for the establishment of a World Influenza Centre were laid down in September 1947 [1] The Interim Commission aware of the danger of a new influenza epidemic, similar to the one which wrought havoc in 1919, recommended the establishment of a central laboratory to collect and distribute information on outbreaks of influenza epidemics to collect and distribute pathological material necessary for the identification of the type of virus and the preparation of corresponding vaccines and to train laboratory workers from other countries The proposed centre was established in 1948 and Dr C H Andrewes assumed its direction -

To facilitate identification of the type forms responsible for the present epidemic WHO had asked that throat washings or fresh sputum for testing for virus should be submitted for laboratory investigation packed in ice or dry ice (CO_2) and dispatched by air or otherwise so that they reach the laboratory within 24 hours of being obtained Specimens sent by ordinary post were not considered worth testing It was recommended that throat washings be obtained by the patient gargling 15 ml physiological saline solution and spitting this into a container, to which 5 ml bacteriological broth should be immediately added and the whole put as quickly as possible in refrigeration

Health administrations were requested to co operate in this investigation by submitting for test appropriate samples to the World Influenza Centre or to the nearest regional laboratory working in conjunction with it the names and addresses of which were listed in the *Weekly Epidemiological Record* 1949 24 18

Type of Virus incriminated

France On 12 January a telegraphic message from the WHO World Influenza Centre indicated that Dr Lépine of the Institut Pasteur had identified virus A as the cause of half the current cases in France and had reported that the other half were due to a strain which seemed unrelated to either A or B These findings were confirmed on 15 January in a telegram received from the French Ministry of Public Health

[1] *Chron World Hlth Org* 1947 1 1 5

[2] *Ibid* 1948 2, 44

Netherlands On 12 January WHO was informed by cable from the Hague that virus A had been definitely identified in the southern part on serological evidence by Prof J Mulder of the University of Leyden although the sub-type was not clear In a later report Prof Mulder stated that the Dutch virus appeared to be related to the 1947 A type which caused an extensive epidemic in Sweden and lesser epidemics in Holland the United Kingdom and the United States of America

EASTERN MEDITERRANEAN CONFERENCE

The representatives of approximately twenty countries of the Eastern Mediterranean region will be meeting in Cairo on 7 February to set up a regional organization in that area in accordance with the decision taken by the first World Health Assembly It will be recalled that the Assembly made provision for the establishment of six regional organizations and delimited their respective zones [1]

The Regional Organization for South-east Asia comprising Afghanistan Burma Ceylon India and Siam was set up first, with headquarters in New Delhi and started activity in the beginning of 1949 [2]

A special office for the health rehabilitation of European countries devastated by the war — an office which is not intended to form part of any scheme for regional organization — has just been opened in Geneva at the headquarters of WHO Its purpose is to help those countries whose health problems are serious as a result of the war and which lack drugs medical supplies and personnel [3]

The object of the Cairo Conference is to integrate the Sanitary Bureau at Alexandria [4] with WHO and to establish an office for the Eastern Mediterranean which according to the Constitution of WHO will form the administrative body of the Regional Organization

The Eastern Mediterranean region comprises Aden British Somaliland Cyprus Egypt Eritrea Ethiopia French Somaliland, Iran, Iraq Lebanon Pakistan Palestine Saudi Arabia Syria Transjordan Tripolitania Turkey and Yemen [5] France and the United Kingdom have been invited to participate in the Conference to represent those territories whose external affairs they administer

Chr W ld Hl h Org 1948 2, 191

Ibid 1948, 2, 225

Ibid 1948 2, 275

For account f the Bureau, see *Off R World Hlth Org* 12, 65

Greece, which originally appeared on the list f countries belo ging to the Eastern Mediterranean, has requested th it be ttached to the European Region.

SEROLOGY OF SYPHILIS

The Expert Committee on Venereal Infections has suggested that WHO might usefully seek to establish a uniform level of reactivity in serological tests for syphilis, as well as a repository for the resulting reference standard antigen It was unanimously recognized that there was a pressing need for the correction of the many discrepancies arising largely from the use of tests in which the level of reactivity had been decided individually by the originator of each method Moreover no concerted effort has been made to decide upon a uniform level of sensitivity and to adjust the various test methods to that level It is of great importance, moreover, that the level of reactivity determined upon should be the most suitable for the diagnosis of syphilis while remaining as far as possible unaffected by reacting substances produced by diseases other than syphilis Until this optimal level has been defined discrepancies will continue to occur whenever several tests are employed

The advent of cardiolipin lecithin antigens has made possible the preparation of antigens of almost any desired degree of reactivity Once the optimal level has been determined, an antigen designed as a reference standard can be prepared and made available for use by any laboratory or commercial concern wishing to manufacture antigens for a given test.

Studies on Serological Tests

The committee has also considered the studies carried out by WHO on serological test performance in the principal laboratories in Ethiopia and Bulgaria Similar test performance evaluations will shortly be carried out in Poland, and, eventually in several other countries In this work WHO used the United States Public Health Service venereal-disease research laboratory in New York as an international serological reference centre While furnishing guidance to the laboratories themselves, these studies also help to determine the effect of transportation on serum samples under various conditions Experience of considerable value to national standardization is accumulating, and this is an important preliminary to the contemplated *International Serological Laboratory Conference*.[1]

The committee recommended that a sub-committee of not more than 4 members, on serology and laboratory aspects be established as soon as possible, and that a preliminary programme for the International Serological Laboratory Conference be drawn up at an early date for consideration by the committee.

[1] *Chron. World Hlth Org.* 1948, 2, 33

Influence of Environmental Factors

Preliminary ob ervations in certain countries have led to the belief that environmental factors may be responsible for a high percentage of positive serological findings in some population groups in which the disease is comparatively rare Without more complete and precise knowledge of this phenomenon it may be difficult to determine the extent of syphilis in a given area or the effectiveness of any control measures taken and WHO experts consider that a thorough study of the problem is essential

Only by means of large scale clinical and laboratory investigation of representative population groups in different geographical areas could this study be attempted Careful attention would have to be devoted to the relationship between positive serological findings and seasonal and climatic factors diet and standard of living and the simultaneous existence of other infections

Members of the expert committee were unanimous in recommending that WHO should undertake research on this question

PENICILLIN IN VENEREAL DISEASES

Although penicillin is of vital importance for the treatment of diseases other than venereal infections there are indications that should it become freely available all over the world by far the largest proportion of the drug would be consumed in the treatment of syphilis and gonorrhoea

Ambulatory Treatment

High hopes were placed by the WHO Expert Committee on Venereal Infections on the potentialities of ambulatory treatment in venereal diseases The committee examined the reasons for failure in the penicillin treatment of syphilis and gonorrhoea reported on several occasions in the medical press Experience in the penicillin therapy of syphilis is now based on more than half a million cases in the United States alone extending over a period of more than 5 years but the fact was emphasized that much of the early work was performed with pharmaceutical preparations which were imperfect in quality and variable in unitage Dosage schedules were tentative and below the minimum now considered necessary Further since this therapy frequently relied on injections given at short intervals over a period of time mass treatment of syphilis by this method tended to be dependent on the number of hospital beds available and upon the cost of hospitalization during the required period Although in some countries such as the Scandinavian countries and the United Kingdom it may be possible to

keep a relatively large proportion of patients under this kind of treatment without hospitalization the procedure required in early penicillin therapy was not suitable for ambulatory treatment

Production and Availability

The WHO Secretariat submitted to the committee a summary of data from 71 countries showing the very limited production of penicillin and the worldwide need for it On the basis of this and other evidence the committee was convinced that the limited availability of penicillin is the chief restricting factor in venereal disease control in the world today and considered itself justified in continuing to support WHO in its efforts to encourage production and ensure an equitable distribution to all countries particularly those where penicillin is not now available

Experiments have recently been carried out for the production of penicillin without the usual growth media which are often difficult to obtain in sufficient quantities and using instead a substance which is generally available and which contains similar growth factors It was suggested that WHO might well assume responsibility for the promotion on a wide scale of such processes which promise to increase the production and availability of penicillin

Funds have been supplied by WHO for a survey of the needs of UNRRA penicillin plants in certain European and Far Eastern countries but no grant will be made from UNRRA residual funds for reconditioning these plants The committee therefore recommended that other means of getting these plants into operation should be considered as soon as the contemplated survey had been carried out It was suggested that in the meantime the matter might be studied by the United Nations Economic Commission for Europe as industrial rehabilitation is one of its concerns

Finally the committee felt that WHO should be prepared to advise on the quality and standard of the various types of penicillin penicillin in oil and beeswax (POB) procaine penicillin in oil procaine penicillin in oil with aluminium monostearate or other types

WHO Publications

New International Statistical Classification of Diseases and Causes of Death

Copies of the *Manual of the International Statistical Classification of Diseases Injuries and Causes of Death* are now available The first impression of 20 000 copies, is already sold and a second is in the press

This publication, which appears first in English outlines the procedures to be followed in the compilation and publication of morbidity and mortality statistics as adopted by the Sixth Decennial Revision Conference held in Paris April 1948 It is planned that there shall be editions in French and Spanish

The *Manual* differs appreciably from the official documents issued after previous revision conferences in that it provides for the first time a single list for coding both diseases and causes of death it will therefore meet the needs not only of vital statistics offices, but also of hospitals clinics social security administrations and other agencies compiling morbidity statistics An extensive *Tabular List of Inclusions* — i e a list of diagnostic terms defining the content of each category of the list — and an even more comprehensive *Alphabetical Index* both of which are included in the *Manual* will contribute considerably to the uniform assignment of diagnoses to the various titles of the classification

Three shorter lists for tabulation of routine morbidity and mortality statistics represent a further innovation The *Manual* also contains as a new feature an *International Form of Medical Certificate of Cause of Death* and gives rules for classification which place upon the certifying physician the responsibility for indicating the underlying cause of death to be shown in primary tabulations

Included in the *Manual* also are WHO Regulations No 1 regarding nomenclature with respect to diseases and causes of death, which were adopted by the first World Health Assembly to ensure as far as possible the uniformity and comparability of statistics of diseases and causes of death This international law coming into force on 1 January 1950 regulates the various steps in the compilation and publication of morbidity and mortality data

Unlike its predecessors, the new international *Manual* will be used as such and not merely as a basis for the preparation of national manuals Only countries unable to utilize the international version in any of the languages in which it is published will find it necessary to prepare corresponding national manuals

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 (a) List of three-digit Categories (Detailed List)
 (b) Tabular List of Inclusions and four-digit subcategories
4 Medical Certification and Rules for Classification
5 Special Tabulation Lists
 List A Intermediate List of 150 Causes for Tabulation of Morbidity and Mortality
 List B Abbreviated List of 50 Causes for Tabulation of Mortality

List C. Special List of 50 Causes for Tabulation of Mortality for social security purposes

6 Suggested Form of Multiple Cause Tabulation

7 WHO Regulations No 1 Regarding Nomenclature with respect to Diseases and Causes of Death

Volume 2

Alphabetical Index

International Digest of Health Legislation

The first number of the *International Digest of Health Legislation* has now been published in English and in French It forms a successor to the first section of the *Bulletin mensuel de l Office International d'Hygiène Publique* the last number of which appeared in December 1946 on the transfer to WHO of the duties and functions of OIHP

The *Digest* will consist of reprints and translations of or extracts from the texts of the most important laws and regulations dealing with public health and related subjects adopted in different countries It is intended for all who are interested in the administrative and legislative aspects of public health

This number contains the text of the following

Australia (Western Australia)

Regulations Registration of nurses
By laws Eating houses

Belgium

Order Control of sera vaccines etc
Order Milk trade
Decree Private slaughter houses

France

Order Laboratory equipment
Decree State Diploma in Child Welfare
Decree Commission for the general supervision of training and probation periods established for the State Diploma in Child Welfare
Order Exercise of the nursing profession (male and female nurses)
Order Narcotic drugs
Order Formulae of medicaments
Decree Medical ethics
Decree Consultative Commission on New Therapies
Decree *Regulations governing blood transfusion and resuscitation centres*
Decree Commission on Mental Hygiene
Decree Regulations governing the exercise of the professions of medical masseur and gymnastics instructor and of chiropodist
Decree Regulation of the profession of medical masseur and gymnastics instructor
Decree Entrance examination for schools *preparing for the State Diploma* for Masseur Kinesitherapists
Decree Declaration of tularaemia
Decree Sale of raw milk for human consumption
Decree Serological examinations for the diagnosis of syphilis
Decree Commission on the Therapeutic and *Biological Uses of Radio-Isotopes*
Decree Interment exhumation cremation and transport of corpses
Decree *State Diploma for Social* Workers of both sexes State Diploma for Hospital Nurses of both sexes

Decree Medical examination
Decree Commission on Sanitary Questions
Decree Commission for the Study of Sanitary Questions
Decree Medical supervision for staffs of teaching and educational institutions
Decree Title of specialists provided und r Article 22 of the general schedule of professional registers

French Cameroons

Order Medical surveillance

Gold Coast

Ordinance Lunatic asylums

(North West Frontier Province)

Act Vaccination

Indo-Chinese Federation

Order Public health

Ireland

Order Milk and dairies

Lebanon

Maritime Code (safeguarding of seamen s health)

Northern Rhodesia

Ordinance Births and deaths registration

Nyasaland

Regulations Registration of medical practitioners

Southern Rhodesia

Regulations Aviation hygiene

Sudan

Regulations Quarantine

Tunisia

Order Smallpox vaccination

Union of South Africa

Regulations Registration of medical practitioners
Regulations Health services
Regulations Health services

United Kingdom (Scotland)

Regulations School health

Epidemiological and Vital Statistics Report

The *Report* is bilingual, English and French, and is published monthly Contents of the latest numbers are

Vol I No 15 (August 1948) An article on the present state of population growth and tables showing birth rates for certain countries and for large towns

Vol I No 16 (September 1948) Tables of statistics of cerebrospinal meningitis and poliomyelitis

Vol I No 17 (October 1948) Tables of statistics of whooping cough, diphtheria measles and scarlet fever

Notes and News

Fifty-eight Nations Members of WHO

By July 1948 54 countries had ratified the Constitution of WHO and had taken part as Member States in the first World Health Assembly During the following months three South American States Chile Argentina and Paraguay deposited their instruments of ratification bringing the number of Member States of the Organization to 57

Paraguay is the tenth member of the Pan American Sanitary Organization to join WHO This accession is a further step towards the integration of PASO with WHO The Pan American Sanitary Organization will act as the regional organization of WHO in the American region as soon as 14 of its Member States have become Members of the World Health Organization [1]

Lebanon deposited instruments of ratification at Lake Success as of 19 January and as announced elsewhere in this issue will be sending delegates to the WHO Regional Conference for the Eastern Mediterranean [2] This brings the number of Member States of WHO to 58

Periods of Validity of Immunization Certificates

The Section on Quarantine of the Expert Committee on International Epidemiology and Quarantine which met in Geneva on 18 November 1948 requested the WHO Secretariat to advise national health administrations that the periods of validity of certificates of immunization against cholera smallpox and yellow fever as laid down in the texts of the International Sanitary Conventions of 1944 are to be interpreted as follows

Certificate	*Period of validity reckoned from the date of immunization*
Inoculation against cholera	7 days to 6 months
Vaccination against smallpox	14 days to 3 years
Inoculation against yellow fever	10 days to 4 years (except in the case of persons reinoculated within 4 years)

Venereal Diseases

Dr José Amador Guevara (Costa Rica) has been appointed WHO Expert consultant in venereal diseases to the Philippine Government Dr Amador Guevara was a member of the medical teaching mission sponsored jointly by WHO and the Unitarian Service Committee of America which recently visited the Philippines at the request of the Government [3]

Dr Alain Spillmann (France) has spent one month in Italy as a WHO expert consultant studying the venereal disease situation and helping to establish demonstration programmes in several cities Such a programme is already in operation in Naples with excellent results

[1] *Chron World Hlth Org* 1948 2 235

[2] See p 13

[3] *Chron World Hlth Org* 1948 2 263

Czechoslovakia also has requested technical assistance from WHO in developing plans for the control of venereal disease Dr James Lade (USA) has been assigned to assist local authorities

Fellowships in Venereal Diseases

The Expert Committee on Venereal Infections at its second session held in October in Paris recommended that fellowships for the study of venereal diseases be classified into two groups

(*a*) for senior physicians and personnel short term travel grants 3 to 6 months

(*b*) for physicians laboratory workers, public health nurses or social workers 3 months to 1 year s training.

Conference on Penicillin Production

The temporary special office in Geneva for health rehabilitation in Europe [1] has called a conference for 17 February in Geneva which will bring together technical experts from a number of countries where the penicillin plants supplied by UNRRA are located Representatives have been invited from Byelorussia, Czechoslovakia, Poland Ukraine and Yugoslavia, and specialists in penicillin production methods from England and Denmark have been asked to attend It is hoped that from this meeting more detailed information will emerge on the possibilities of using the former UNRRA plants as part of the general effort to make large amounts of penicillin available to those areas which are in most need of this drug.

WHO Representative for Palestine Relief

Dr J D Cottrell, Medical Officer of WHO has been appointed WHO representative for UN Palestine Refugee Relief Dr Cottrell who comes from New Zealand, and has wide experience of medicine and of public health administration returned recently from Austria where he directed the WHO field mission He was formerly attached to UNRRA

Dr Cottrell has stated that, according to the latest reports received in Geneva, the health conditions of the 700 000 refugees in Palestine and neighbouring States are such that energetic action is urgently necessary Typhoid fever dysentery and other intestinal diseases are causing havoc among them, and in particular immediate action against malaria is needed, as many refugees are at present living in highly malarious regions

Recent and Forthcoming Meetings

24 January	Expert Committee on Habit forming Drugs first session, Geneva
24-28 January	Expert Committee on Maternal and Child Health, first session Geneva
28 29 January	WHO/UNESCO Executive Committee of the Organizing Committee for the Co-ordination of International Congresses of Medical Sciences Paris
7 February	WHO Conference of Eastern Mediterranean Countries Cairo
17 February	Conference on UNRRA penicillin plants, Geneva
21 February	WHO Executive Board third session Geneva
14-15 March	Joint Committee on Health Policy UNICEF/WHO Geneva

[1] *Ch on World Hl h Org* 1948 2, 775

March (tentative)	WHO Regional Committee for South East Asia second session New Delhi
20 April	Expert Committee on the Unification of Pharmacopoeias fourth session Geneva
27 April	Sub-Committee on Fat soluble Vitamins first session London
2 May (tentative)	Expert Committee on Biological Standardization third session London
13 June	Second World Health Assembly Rome

PUBLICATIONS OF THE WORLD HEALTH ORGANIZATION *

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual English and French)

This publication intended for national health-administrations and for health services at ports and frontiers, contains notifications concerning diseases qualified as "pestilential" in the International Sanitary Conventions as well as other information about the application of these Conventions.

It is mainly intended for official use and is not for sale separately. It can however be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below)

EPIDEMIOLOGICAL AND VITAL STATISTICS REPORT

(Bilingual English and French)

The *Report* is published monthly and contains statistics on infectious diseases, mortality rates etc. The statistical information is supplemented by various articles and notes on epidemiological and demographic subjects.

Subscription for 1949	25/	$5.00
Price per single copy	2/6	$0.50

Annual subscription including the *Epidemiological and Vital Statistics Report* and the *Weekly Epidemiological Record* for the use of libraries, medical schools etc. £2 $8.00

OFFICIAL RECORDS OF THE WORLD HEALTH ORGANIZATION

(Separate editions in English and in French)

The fifteen volumes of the Official Records so far published mark the successive stages in the evolution of WHO. They comprise

No. 1 Technical Preparatory Committee for the International Health Conference

—containing the minutes, with supporting documents, of the Paris meeting of March-April 1946, at which the form and scope of the future Organization were discussed and its Constitution tentatively drafted.

No. 2 International Health Conference

—proceedings of the Conference held in New York in June-July 1946 which terminated in the signing of the WHO Constitution. The volume contains, besides the texts of the Constitution and other relevant Acts, a summary report on the Conference, minutes of the plenary meetings, and supporting material.

All prices are post free

No 3 First session of the Interim Commission

No 4 *Second session of the Interim Commission*

No 5 Third session of the Interim Commission

No 6 Fourth session of the Interim Commission

No 7 Fifth session of the Interim Commission

— each containing minutes and supporting documents

No 8 Reports of expert committees

(biological standardization malaria preparation of the sixth decennial revision of the International Lists of Diseases and Causes of Death quarantine revision of the pilgrimage clauses of the international sanitary conventions tuberculosis unification of pharmacopoeias venereal diseases)

—as submitted to the Interim Commission

No 9 Report of the Interim Commission (Part I Activities)

—the résumé of its work submitted by the Commission to the first World Health Assembly

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No 15 Reports of expert committees

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Malaria control by residual indoor spraying with DDT by E. J PAMPANA

Trials of causal prophylaxis of malaria with paludrine by M CIUCA L. BALLIF and M. CHELARESCO

Preliminary note on therapy of malaria with paludrine, by M CIUCA A. SOFLETE, P CONSTANTINESCO and E. TERTEANU

Species-eradication the eradication of *Anopheles gambiae* from Upper Egypt 1942 1945 by Sir Aly Tewfik SHOUSHA, Pasha

Cholera epidemic in Egypt (1947) a preliminary report, by Sir Aly Tewfik SHOUSHA, Pasha

Price 7/6 $1.50

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VOL. 3 No 2

FEBRUARY 1949

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VOL. 3 No 2 FEBRUARY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

TUBERCULOSIS IN INDIA

The report of the Bhor Committee revealed that about 500 000 people die annually from tuberculosis in India This means that the annual number of cases is approximately two and a half to three million out of a population of 320 million

The main reasons for this high morbidity rate are threefold bad housing lack of sanitation and malnutrition Because of a very large population the housing situation in India is far from satisfactory two or three families sometimes comprising as many as ten people have in many cases to share one room Added to the lack of sanitation and the food shortage which is such that many people are living on the verge of starvation this creates a situation in which the danger of infection is obvious

There are further constant movements of the population between the towns and rural areas the village people come into the towns for the markets while the city people make frequent visits to their native villages This natural tendency has been accentuated by the growth of new industries which have attracted to the towns large masses of people most of whom are very poor

The situation is in general slightly worse in the towns owing to greater overcrowding but sanitation and nutrition are equally bad in the country and the danger of infection is increased by the interchange of population between town and country

It is obvious that no quick solution will be possible for the problems resulting from the constant movement of population and from the industrialization of the country Both these factors will continue for a long time to confront the health authorities with increasing difficulties It will take time and colossal sums to improve the sanitation the housing conditions and the food situation

It is however equally clear that tuberculosis causes untold suffering and serious economic loss in India and that there is urgent need for action of some kind

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Note — The *Ch onicle of the Wo ld Health Organi.ation* is published monthly in English French, Russian, Spanish and Chinese The *Chro icle* reports the activities of the Organization, without, however claiming to be an authoritative record of its official views, which are set out in the *Official Reco d of the Wo ld Health O ganization* All correspondence relating to it should be addressed to the World Health Organization Pala s des Nations Geneva Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom, more especially in the medical Press, are entirely at liberty to do so

immediately formed to work out the details always in consultation with Dr Gellner and Dr Benjamin Financial difficulties seemed to stand in the way of an early implementation of those plans they were however overcome by the readiness of the Central Government to contribute half the cost of the campaigns in the different provinces

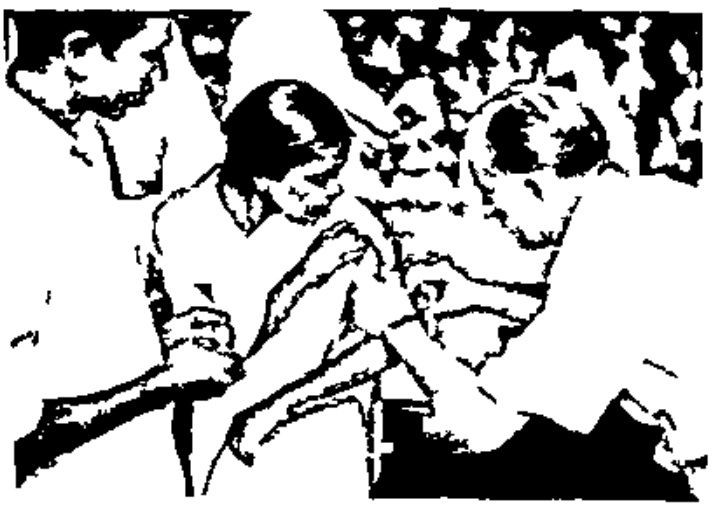
FIG 2. ALL INDIA BCG CAMPAIGN II



Centre Rajkumari Amrit Kaur Minister of Health India back, left D K C K E Raja back, right D C Mani right D P V Behman

The preparatory work for the establishment of the BCG laboratory actually began several months before the departure of the WHO experts for India Acting on the assumption that it might be difficult to procure the necessary instruments materials etc in India they proposed to the government that all the equipment should be purchased in Europe with the object not only of saving time in setting up the laboratory but also of employing only such equipment as had proved its usefulness in BCG laboratories in Europe especially in the State Serum Institute Copenhagen When the Government of India had agreed to the proposal all the many articles of equipment — from incubators and analytical scales to filter paper ampoules boxes and labels — were purchased and shipped to India This operation was so well timed that the shipments landed in India very shortly after Dr Gellner's and Dr Lind's arrival there which made it possible to set up the laboratory in the King Institute at Guindy Madras in the

FIG 3 ALL-INDIA BCG CAMPAIGN III



Dr P Lind WHO expert, giving a BCG vaccination

Possible Measures of Control

The question is what measures are possible? Hospital accommodation is quite inadequate For the treatment of tuberculosis 500 000 hospital beds would be needed but at present only 7,000 are available Attempts are being made all over the country to increase the number of sanatorium beds, but at an optimistic estimate only 30,000 beds could be added within the next few years to the number at present available

FIG 1 ALL INDIA BCG CAMPAIGN I



Left Dr C Mani Deputy Director General of Health Services India now Director of WHO Regional Office for South East Asia right Dr K C K E Raja Director General of Health Services India

In view of this situation the authorities have turned their attention to prevention of the disease by BCG vaccination in the hope of reducing the problem within a number of years to such proportions as to bring its control more within the financial possibilities of the country

There were nevertheless great difficulties in the way of a BCG vaccination campaign in India The first requirement was tuberculin for large scale tests this was not available in India and would have to be imported Secondly there was no institute in Asia capable of producing BCG vaccine Thirdly, there was no trained personnel in India

Technical Assistance by WHO

To overcome the difficulties the Government of India requested aid from WHO and in response to this Dr W Gellner and Dr P Lind were sent to India to set up a BCG laboratory and to demonstrate BCG vaccination on a mass scale

The first discussions took place with the Central Government and with Dr P V Benjamin, tuberculosis adviser to the Government of India Throughout his stay of seven months Dr Gellner worked in close collaboration with Dr Benjamin

During the month of June 1948 the two experts visited a number of cities — Madras Bombay Calcutta, Delhi and Baroda — to contact the provincial health authorities and to discuss plans with them They met with great interest and co operation everywhere Local committees were

The co-operation which the WHO team gained both in official quarters and among the general population was very good and augurs well for the success of the more extended campaign which is to begin now with the aid of the United Nations International Children s Emergency Fund (UNICEF) This organization — in agreement with WHO — is sending six BCG teams together with the necessary transport and equipment to India where they will be distributed among those capital cities which have already made some preparations for this work

The function of the UNICEF teams will be to train Indian doctors in the requisite techniques So long as the Indian health authorities can provide a sufficient number of doctors to work with the foreign teams and to carry on and enlarge their work after the latter have left it is to be hoped that a systematic BCG campaign will in the course of time materially affect the incidence of tuberculosis in India

EXAMINATION OF NEW HABIT-FORMING DRUGS

Many new synthetic anaesthetics and analgesic drugs for use as substi tutes for morphine have been evolved in the past few years The question now arises whether these drugs will p ove to be habit forming and thus belong to the group of substances governed by the Conventions of 1925 and 1931 or whether on the other hand as substances which are compounded and which in practice preclude the recovery of the said drugs they may be exempted from such control The WHO Expert Committee on Habit forming Drugs at its first session in Geneva 24-29 January [1] was required to make recommendations on this question and to consider requests received from governments during recent years for the exemption from control of several types of drugs

The Economic and Social Council of the United Nations is the authority responsible for notifying governments of the drugs which are placed under the international conventions governing narcotic drugs The WHO expert

The following were present at the session

Members

Dr J Bouquet, ex-Inspecteur des Pharmacies, Tunis, Tunisia
Dr N B Eddy Principal Pharmacologist, Division of Physiology National Institute of Health (US Public Health Service) Washington, D C., USA (Chairman)
Dr J R. Nicholls, Deputy Government Chemist, Government Laboratory London United Kingdom
Dr P O Wolff Buenos Aires, Argentina

Secretary

Dr R. Grsetic Assistant Director-General, WHO

Observers

M L F Atzenwiler Assistant Secretary of the Permanent Central Opium Board and Drugs Supervisory Body United Nations, Geneva, Switzerland
M A. E. F Ikin, Secretary of the Permanent Central Opium Board and Drugs Supervisory Body United Nations, Geneva, Switzerland
M V Pastuhov Chief of Section, Division of Narcotics, Department of Social Affairs, United Nations, Lake Success, USA

Professor H. Fischer (Zurich) was present at the meetings on 25 and 26 January as a member of the Permanent Central Opium Board and Drugs Supervisory Body

Absent Dr H P Chu, Professor of Pharmacology National College of Medicine Shanghai, China

record time of a few weeks Production of the vaccine actually started about the middle of July and the first Indian BCG vaccine was available on 17 August 1948

Sir Sahib Singh Sokhey, director of the Haffkine Institute, Bombay and a member of the WHO Expert Committee on Biological Standardization, visited the new BCG laboratory at the request of WHO and after examining the installations and methods of culture certified that the BCG vaccine produced at the laboratory conformed to a satisfactory standard

FIG 4 ALL INDIA BCG CAMPAIGN IV



Dr W Gellner WHO expert, giving a BCG vaccination

The all India BCG vaccination campaign was officially inaugurated in Madanapalle South India on 11 August 1948 by the Indian Minister of Health Rajkumari Amrit Kaur[1] Madanapalle a town of about 16 000 inhabitants thus became the scene of the first application of BCG in India within the framework of a general scheme for tuberculosis control which includes prevention (BCG vaccination) diagnosis by mass radiography, and treatment of discovered cases From 1 August to 20 October 1948 approximately 6 000 persons — mostly schoolchildren — were tuberculin tested and the negative reactors (about 2 000) received BCG vaccination Twelve doctors from different parts of the country had been trained in the theory and practice of BCG vaccination

The work in Madanapalle which aims at the vaccination and mass radiography of the total population was taken over by an Indian doctor when Dr Gellner left, towards the end of October 1948 for Delhi to start a second demonstration centre there

In Delhi, between the end of October and 18 December 1948, over 10 000 persons were tuberculin tested and over 5 000 received BCG vaccination while three doctors were trained in the work The schoolchildren who formed the greater part of the tested and vaccinated persons were dealt with in their schools while two clinics — one in Delhi and the other in New Delhi — were established for the pre school children and young adults

[1] *Chron World Hlth Org* 1948 2 229

care synthetic drugs of similar structure to those already examined which may prove to have habit forming properties With reference to the experience already gained with substances of the Dolantin and Methadone groups the committee recommended that any new convention should provide that substances of a particular chemical type analogues of which have proved to be habit forming be placed under control until such time as they are shown not to be habit forming

Heroin (diacetylmorphine) The committee expressed its alarm that although the dangerous nature of heroin is now universally recognized consumption of this drug has increased considerably in certain countries Heroin is known to be more toxic than morphine as its analgesic effect is from four to eight times more powerful Its effect on the nervous system is much greater and 0 007 g of heroin is sufficient to induce respiratory paralysis Over the last fifty years heroin has caused great havoc in the world It is strange to note that in some countries heroin continues to be widely prescribed while others have completely ceased to use it The committee was of the opinion that further information was urgently needed on the reasons for the continued use of considerable quantities of heroin in some countries Such data might be obtained through the World Medical Association In addition direct inquiries might be undertaken on the spot by sending experts to ascertain from local physicians and sickness insurance services the reasons why this drug is prescribed in preference to others

Morphan The committee was informed that German and American chemists have produced by direct synthesis a compound known as Morphan in which the structure of the naturally occurring morphine alkaloid has been very nearly attained This difficult synthesis is not at the moment a commercial possibility but the synthesis of other compounds related to morphine is going forward and the progress of this research should be watched very carefully

Finally the committee was impressed by the variety of names given to the same drug by different manufacturers Indeed to avoid ambiguity it had been necessary to give the full chemical formula of these substances The committee drew attention to the advantages which would result if each substance could be given a recognized name by some authoritative and preferably international body

VENEREAL-DISEASE CONTROL IN POLAND

The incidence of venereal diseases increased significantly in Poland as a result of the devastation of war and the occupation The health of the population particularly that of the younger generation suffered and venereal diseases contributed much to the decline in the birth rate and to

committee acts as an advisory body If approved by the Executive Board of WHO its recommendations for the addition of new drugs to the list of substances subject to control or for their possible exemption are trans mitted to the Economic and Social Council This procedure follows that established by the League of Nations and was accepted by the signatories to the Protocol of 11 December 1946 by virtue of which the functions and powers of the Health Committee of the League of Nations and of the Office International d Hygiene Publique were transferred to WHO * On 19 November 1948 the United Nations adopted a new protocol bringing under international control the synthetic products discovered during and since the war Forty six Members and six nations which are not members of the United Nations have already signed this protocol

After considering the reports submitted by experts on each of the drugs under examination the committee recommended that the following sub stances and groups of substances be brought under the existing international conventions on account of their habit forming potentialities

Valbine This drug is subject to control on account of its content of dihydrooxycodeinone hydrochloride of the possibility of recovering this alkaloid from the preparation and of the presence of a barbiturate which constitutes an additional habit forming danger

Metopon hydrochloride (methyldihydromorphinone hydrochloride) Che mically metopon hydrochloride is a morphine derivative it is a more powerful analgesic than morphine and has approximately the same pro perties as regards tolerance and habit forming

Acetylcodone (acetyldihydrocodeine hydrochloride) Although no spe cific information was available on its habit forming properties the com mittee considered that this substance should be placed under control because it is convertible to dihydrocodeine which in turn is convertible to dihydro morphine a habit forming drug These considerations apply equally to other esters of dihydrocodeine and their salts and to dihydrocodeine and its salts

Dolantin (Demerol, Pethidine Piridosal) (1 methyl-4 phenyl piperidine 4 carboxylic acid ethyl ester) Because of the powerful habit forming properties of this substance and its salts the committee recommended that they should be governed by the provisions of the 1931 Conventions The committee considered that the other substances of the Dolantin type (Bemidone, Keto Bemidone NU 1196 NU 1779) should be noted for appropriate action when the 1948 protocol comes into force

Methadone (Amidone) The same provisions should apply to this drug and substances of similar chemical structure on account of their habit forming properties

Precautionary measures with regard to synthetic substances The com mittee was of the opinion that governments should watch with extreme

* *Chron. World Hlth Org* 1947 1 167

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the increase in the number of stillbirths According to the Polish Ministry of Health, the total decrease in live births may be 40 000 50 000 per year and the case fatality rate due to syphilis alone is estimated at about 11 % On the basis of provisional statistics, it is believed that there were in Poland in 1948 approximately 150 000 cases of early syphilis This represents a considerable human toll as well as an important economic loss to the nation Indeed, it was shown by the American Social Hygiene Association that the efficiency of workers suffering from venereal disease and its consequences is 36 % below normal

The realization of such conditions led the Polish Government to inaugurate what has been recognized as a most extensive and intensive national campaign against venereal diseases, planned and launched with the technical assistance of WHO and material assistance by the United Nations International Children s Emergency Fund (UNICEF)

Organization

The control programme is carried out in two stages a temporary and a permanent part The permanent programme will eventually include the treatment of all cases of venereal disease the improvement of methods of treatment the investigation of contacts, and the development of better methods of public education concerning various aspects of venereal diseases The temporary programme includes the application of recent treatment methods based on penicillin to control syphilis and gonorrhoea within the shortest possible time

The functional units of the entire programme are the consultation services for skin and venereal diseases in the health centres which are located throughout the country Besides these consultation services there is in each main city a dermato venereological service in the hospitals working in close co operation with the health centres In view of the remote distances of some country settlements from health centres and the often limited transport facilities, each provincial health department has been provided with a special mobile anti venereal disease team composed of one physician, one instructor in venereology one female nurse and one driver Every team has access to a fully equipped laboratory

The task of such teams consists mainly of

(*a*) visiting districts with high prevalence of venereal diseases

(*b*) spreading information among the population on the dangers of venereal diseases, with a view to inducing the greatest possible number to report for examination and treatment

(*c*) carrying out mass serological examinations

(*d*) training of local medical and auxiliary personnel, and

(*e*) inspecting consultation and treatment centres

Achievements in 1948

At the request of the Polish Government certain technical aspects of the programme were considered by the Expert Committee on Venereal Diseases in January 1948 and October 1948 The expert committee expressed its approval of the plan and observed that the principles embodied might well be of interest to other countries where conditions similar to those in Poland existed

The planning and elaboration of the programme was completed by January 1948 By April 1948 much of the organizational work relating to treatment facilities had also been completed More than 240 physicians 300 nurses and 250 public health nurses had been recruited by the end of April Postgraduate courses were then organized at which attendance was obligatory for venereal-disease control officers The courses were also open to all other physicians free of charge By 1 July 1948 16 such courses had been organized with an attendance of more than 480 physicians The courses were conducted in the university clinics

The provision of equipment and supplies has proved difficult Although some dark field microscopes were available in health centres many specimens for dark field examination had to be sent to the urban centres of the districts concerned Between January and October 1948 42 dark field microscopes were provided An effort was made to obtain personnel and equipment for the follow up of the patients by means of quantitative serological techniques Trained personnel for this purpose is now available but limited availability of equipment in laboratories restricts its general use

In March 1948 the establishment of mobile squads was initiated These squads were originally intended to reach villages located at great distances from the health centres and to remain in the area until case finding and treatment had been completed The initial experience indicated that the mobile squads might be employed to greater advantage for case finding purposes only with the use of sero-diagnostic mass screening procedures The squads were also important in health education of the public The present programme of these squads includes examination of the entire population living in the area and the direction of positive cases to the nearest health centre Units are usually sent to areas where a high rate of venereal disease is suspected on the basis of information received from medical officers in the districts or the towns The squads distribute literature and anti venereal-disease propaganda and show educational films while the medical officer in charge lectures to the public

While the organization of treatment facilities was still proceeding, supplies and equipment were being made available to the health centres and to the university clinics Some health centres started operating in January and February 1948 but action on a large scale was not started until April when further supplies became available

The educational campaign was also started in April 1948 All the principal newspapers published daily, or every other day, an article on the subject broadcasting stations gave instructive talks 1,200 000 booklets were distributed and 200,000 posters displayed The public was informed of the nature and dangers of venereal diseases the role of alcoholism in facilitating their spread, the epidemiological importance of getting infectious cases under treatment, the necessity for early treatment, the availability of short and adequate treatment based on penicillin the assurance of discretion, and the availability of treatment free of charge

The effect of this campaign was that by early July 1948, there was not sufficient penicillin to meet the demands of patients reporting for treatment a crisis which was relieved by rapid delivery by aeroplane of the necessary amounts of penicillin in oil and beeswax

The Polish campaign concentrates firstly on the communicable phases of the disease, early syphilis being treated with penicillin for 10 days This approach appealed to the public and to the medical and venereal disease officers It was subsequently found practicable to extend the period of administration of penicillin to two weeks for certain cases of syphilis Supplementary arseno bismuth therapy is given for a period of 30 days Although so far it has not been proved that such supplementary therapy improves results in man, a compromise in this respect was necessary in view of the opinions of many practitioners and some university professors whose experience in syphilis therapy in the past had been more from the clinical than from the public health point of view These opinions sometimes influenced the patients to insist on additional treatment

By the end of August 1948, about 43 000 cases of syphilis and about 27,000 cases of gonorrhoea had come under treatment

It was found that the most practicable mass serological test for syphilis for use in Poland was the Chediak method Although not perfect this method offers many advantages from the point of view of ease of obtaining specimens and of postal dispatch to the laboratories By the end of August 1948 about 540 000 persons had been examined Positive tests were further checked with the Kahn flocculation and Wassermann complement fixation reactions A preliminary estimate of the prevalence of syphilis indicates that it ranges from 1 % to 3 % The other case finding mechanism employed was tracing of infectious contacts Information on approximately 18 000 sexual contacts was obtained from the first 20 000 cases of venereal diseases treated and of these 10 000 were found to be positive

Further reports on the progress of the Polish anti venereal disease campaign will be found in forthcoming numbers of the *Chronicle* and a detailed account will appear in the *Bulletin of the World Health Organization*

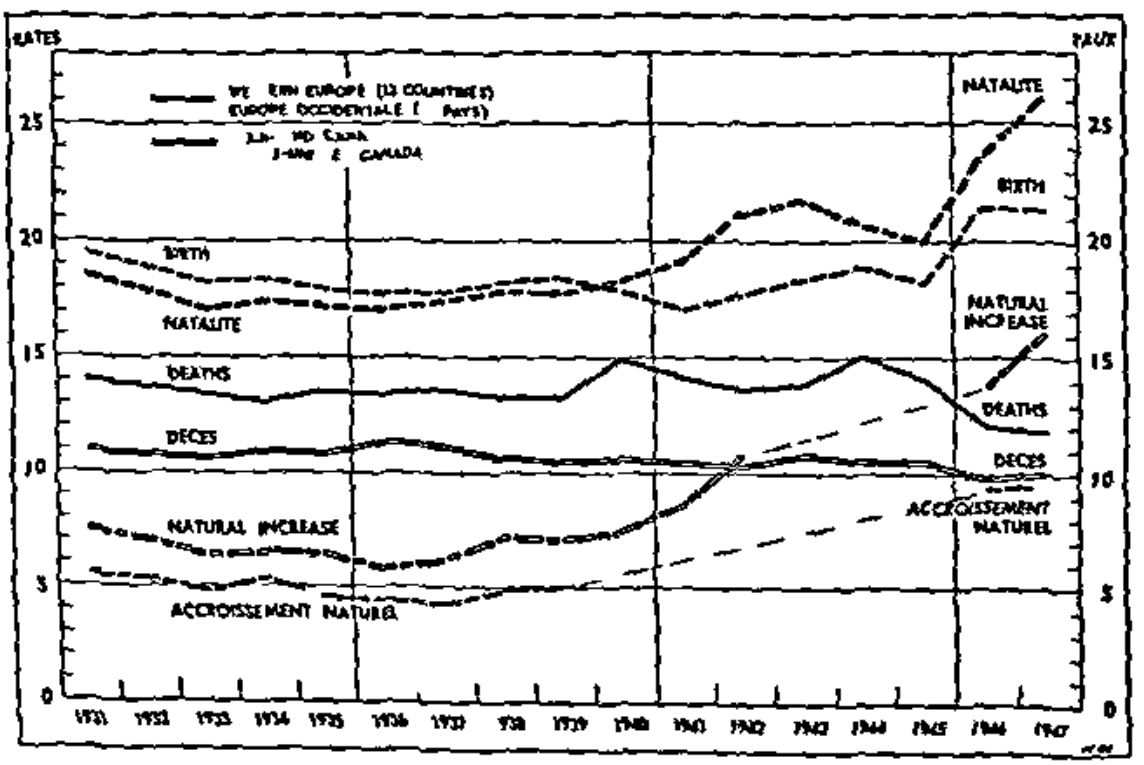
PRESENT STATE OF POPULATION GROWTH

In a recent article in the *Epidemiological and Vital Statistics Report*[1] Mr K. Stowman has reviewed the state of the world's population. On the basis of data now available there can be little doubt that the population of the world has increased more rapidly in the twentieth than in the nineteenth century and the rate of growth is still increasing. In the middle of 1946 the world population was estimated at 2 294 432 000 by the Statistical Office of the United Nations; in 1907 it was estimated at 1 606 000 000 and in 1882 at 1 434 000 000.

North America and Europe

Fig. 5 shows the movement of birth and death rates in two economically important areas of the world — namely (*a*) North America and (*b*) western Europe — from 1931 to 1947. The registration of births and deaths is to all practical purposes complete in the 15 countries in these two areas and it has at no time been interrupted by the war.

FIG. 5. BIRTH, DEATH AND NATURAL INCREASE RATES (PER 1 000 POPULATION) IN WESTERN EUROPE AND IN NORTH AMERICA, 1931-1947



Austria, Belgium, Denmark, Finland, France, Ireland, Italy, the Netherlands, Norway, Portugal, Sweden, Switzerland and the United Kingdom.

For the war years, mortality statistics do not include military deaths occurring abroad. The rates of natural increase have therefore been computed for years where such deaths constitute a significant factor.

[1] *Epidemiological and Vital Statistics Report*, 1949, 1, 33.

In spite of war losses the population of the 13 European co considered increased by about 7,087,000 from 1939 to 1947, as increase of 6 678,000 during the previous eight years The population the United States and Canada increased by 7,700,000 during the eight years and by 14,437 000 during the last eight years until the of 1947

In southern Europe and in France, death rates have fallen rapidly, that they no longer differ materially from those recorded in where reduction of the general mortality began at an earlier date At same time, there has been no postwar increase of the birth rate in sou Europe comparable to that noted farther north

Rate of Growth of Adult Population

It is important to watch the rate of growth of the adult p between the ages of 20 and 60, which may be considered the economica productive ages The number of persons in this age group is determ by (1) the number of births twenty years earlier, (2) the infant and chil mortality during the last twenty years (3) adult mortality, and (4) number of persons reaching the age of 60 In most countries for wh reliable information is available, the birth rate was declining rapid twenty years ago This was counterbalanced to a limited extent only, by the decreasing infant and child mortality The reduction of adult mo tality especially by prevention of tuberculosis, has increased manpower, but has in turn been counteracted by the greater numbers reaching the age of 60

The trend of potential producers differs radically from that of the con sumers, who form the total population The author gives, as an example a statistical table showing the increase, for each five years in total population and in the age group 20 59 in Denmark from 1925 to 1945

The total population increased by 3 4 % from 1925 to 1930, 4 4 % from 1930 to 1935 3 7 % from 1935 to 1940 and 5 2 % from 1940 to 1945 The figures for the population between the ages of 20 and 59, for the correspond ing periods were 7 7 % 8 7 % 5 6 % and 4 6 %

The 1950 total population cannot be forecast with exactitude because the birth rate for 1948 50 cannot be predicted with any certainty, but it seems probable that there will be an increase of about 6 % from 1945 to 1950 On the other hand those who will be between the ages of 20 and 59 in 1950 were born long ago and their death rates are not likely to undergo great changes Short of unpredictable catastrophes the 1950 estimate should therefore be correct to the first decimal The 1950 55 rate of increase of the adult population should be slightly lower than that for 1945 50 after which there may be a rise but it seems unwise to carry estimates farther into the future

At present the ratio between the rate of increase of consumers and that of potential producers can be obtained only in a limited number of countries because detailed postwar censuses will be necessary before valid population data by age can be available It is likely that the results shown above for Denmark will apply in a general way to many other countries and that it will be found that a reversion of trends has taken place during the past twenty years While about 1930 potential producers increased at a much higher rate than consumers the opposite is now the case as a consequence of the rising birth rate and the increasing proportion of old people

The Future Outlook

Comparison of the actual population of western Europe with projections based on prewar trends of fertility and mortality show that the rate of increase in these countries has been much higher than expected war losses notwithstanding Reliable population estimates for the middle of 1947 give 130 396 000 in an area composed of Belgium Denmark France Ireland the Netherlands Norway Sweden Switzerland and the United Kingdom The 1950 population projection for this area was 126 440 000 or about four million less than the actual population in 1947 and the population continues to increase in every one of those countries

What the trend of the birth rate will be for the next few years cannot be predicted However apart from catastrophes arising out of non medical causes it is safe to predict a further substantial fall in the death rate throughout the world due to increased control of tuberculosis malaria venereal diseases water and food borne diseases and of maternal and child health as well as to better care of the sick and the sound

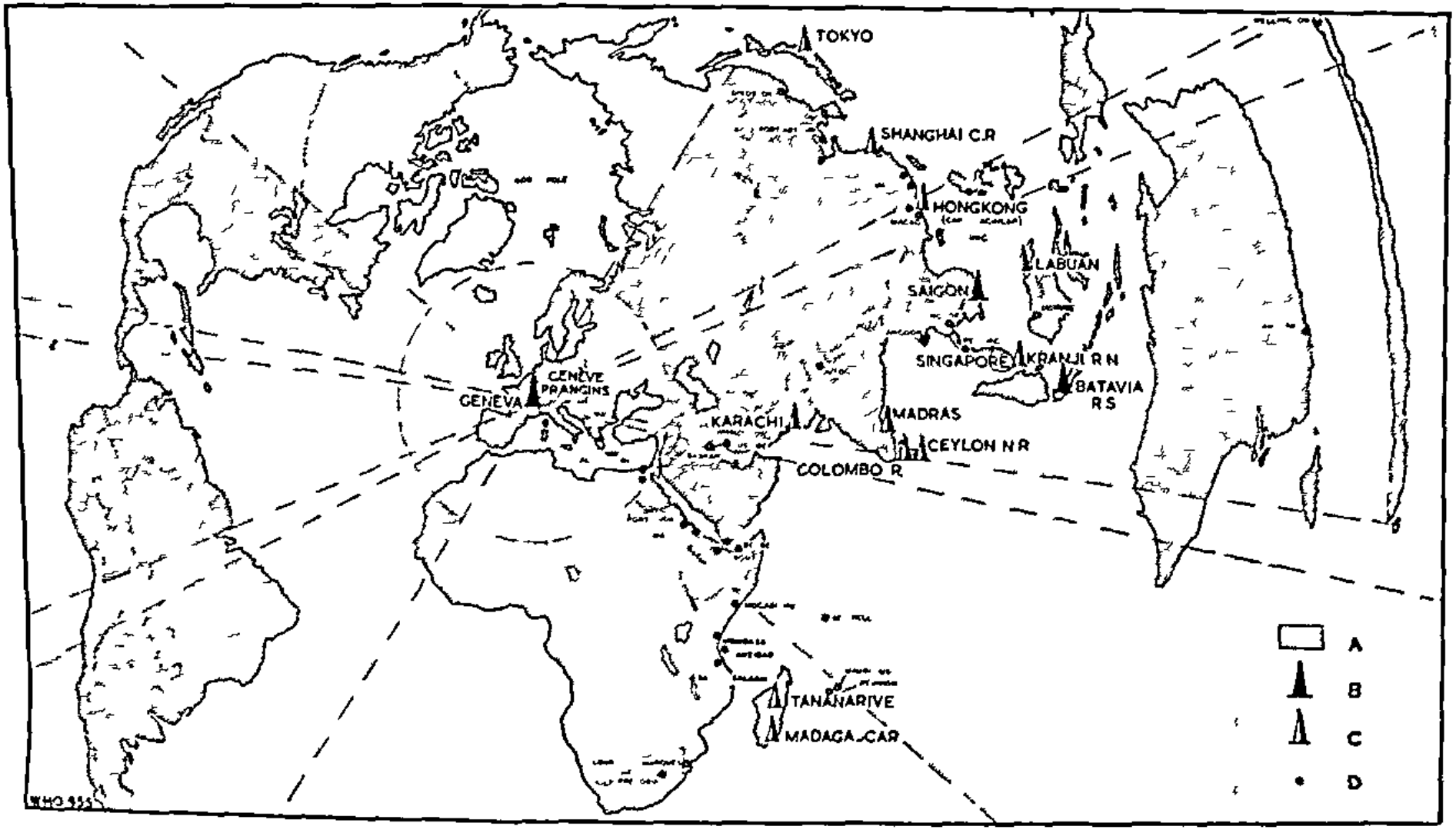
EPIDEMIOLOGICAL RADIO BROADCASTS FROM GENEVA

A new radio service for the benefit of health administrations port and maritime authorities throughout the world was started on 27 January 1949 when WHO broadcast the first of a series of epidemiological bulletins through the Radio Suisse stations at Geneve Prangins

The daily bulletins contain the latest official information on the occurrence of plague cholera yellow fever smallpox and typhus in sea and air ports and on quarantine measures imposed or withdrawn Official information on epidemic outbreaks of any other diseases will also be included in the bulletins if of sufficient international interest

The bulletins are transmitted in clear (non-coded) Morse regularly twice a day over one 50-KW one 6-KW and eight 20-KW stations of Radio Suisse The broadcasts at 15 00 GMT are beamed to North Central

FIG 6 EPIDEMIOLOGICAL RADIO BROADCASTS FROM GENEVA 1



A = Areas reached by Genève-Prangins stations
B = Stations transmitting daily
C = Stations
Wireless statio

and South America and to West Africa the broadcasts at 09 00 GMT cover Europe the Mediterranean area South East Asia Africa Australia New Zealand and the North Western Pacific area Details of the times of the broadcasts with the wavelength frequency and signal call of the stations are shown in table I

Any changes in the list of stations transmitting the bulletins will be announced in the *Weekly Epidemiological Record*

TABLE I

Signal call of the station	Time (GMT)	Wave length (metres)	Frequency (kilocycles per second)	Area covered by station
HBG	9 00	4,800	62 5	Europe
HBO	9 00	44 97	6 672	Europe
HBO	9 00	26 31	11 402	Mediterranean area Africa
HBF	9 00	16 26	18 450	Eastern Mediterranean South East Asia Australia New Zealand
HBZ	9 00	19 12	15 692	
HBH	9 00	16 23	18 480	North Western Pacific Area
HBZ2	9 00	20 64	14 538	
HBV	15.00	15 83	18 950	South America West Africa
HBV2	15 00	15 81	18 970	Central America
HBZ3	15 00	20 74	14 462	North America

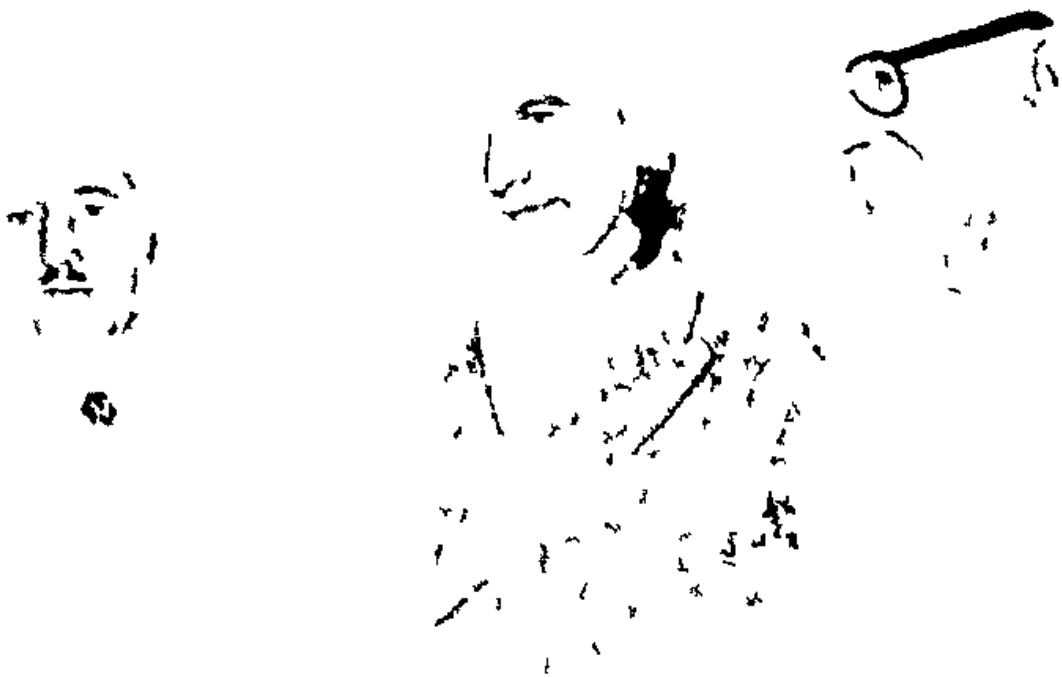
Transmitted in French as well as in English

The introduction of this worldwide service on an experimental basis was approved by the WHO Expert Committee on International Epidemiology and Quarantine at its first session in November 1948 The service is an extension of a similar series of broadcasts transmitted to the Pacific and Indian Ocean area by the WHO Epidemiological Intelligence Station at Singapore This service which has proved its value started under the Health Organization of the League of Nations but was interrupted during the war In 1946 epidemiological broadcasts were resumed to an area covered now by a network of thirteen stations which relay bulletins originating at Singapore

In view of the importance of the new worldwide service advance notification was sent to health administrations of the introduction of the daily epidemiological bulletins suggesting that arrangements should be made for the regular reception of the broadcasts Administrations were asked to report on the quality of the reception of the transmissions and to make suggestions on their contents to the Division of Epidemiology WHO at Geneva It is hoped that the broadcast bulletins will eventually replace the routine telegraphic notifications sent to health administrations under the existing international sanitary conventions Once the regular satis

factory reception of the radio bulletins is assured in any country, the graphic notifications to that country will be discontinued

FIG 7 EPIDEMIOLOGICAL RADIO BROADCASTS FROM GENEVA II



Left M Calame Radio Suisse centre Dr Y Biraud Director Division of Epidemiology WHO right Dr G Stuart Chief Sanitary Conventions and Quarantine Section WHO at inauguration of epidemiological radio broadcasts from Genève Prangins

The advantages of the new service are obvious The epidemiological radio bulletins will enable governments to apply preventive measures as soon as the appearance or spread of an epidemic is reported Similarly the rapid notification of a return to normal conditions will permit the early relaxation of emergency measures

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves Selections from these reports will therefore be published from time to time but it must be emphasized that the opinions expressed are those of the Fellows

Cancer Treatment in the United States

Dr Milos Fort Head of the Prague Institute of Radiotherapy has completed a four months tour of investigation in the United States visiting the most modern clinics specializing in cancer treatment The following are some of the facts which have been taken from his report on cancer research in the United States

The present tendency in the United States is to centralize cancer treatment in institutions built and equipped for this purpose The Memorial Hospital in New York can be regarded as a model centre Provided with the latest equipment, it will soon have a capacity of 600 beds. Treatment by the most modern methods for the various types of tumours is given in specialized departments which, however have common access to hospitalization, research, and treatment services The director is Dr C.P Rhoads, who has specialized in research. The head of clinical services is Dr Allen O Whipple

Surgical treatment of gynaecological tumours has been developed at the expense of radiotherapy Much progress has been made in the surgical exurpation of malignant melanomas and for tumours of the hip or of the iliac bones, exarticulation and iliac section are practised successfully In 1940 a special department was created for thoracic tumour surgery with a laboratory perfectly equipped for the study of delicate thoracic operations on animals The problems of resection and suture of the oesophagus, and of the bronchial stump after pneumonectomy are particularly studied

The preparation of all radiophores is done by a physics department where unique technical installations reduce to a minimum the risks inherent in the handling of radium

The Strang Cancer Prevention Clinic, opened in 1940 and annexed to the Memorial Hospital, provides for all those requiring a complete examination. A widespread campaign in favour of preventive examinations is carried out by broadcasts and lectures. All persons over forty have an x ray examination of the chest and of the gastro-intestinal tract, besides the clinical examination. It is interesting to note that these examinations have resulted in the discovery of comparatively few cases of cancer

Dr Jacox, in his department at the Presbyterian Hospital, is one of the few doctors who perform needle punctures in tumours of the cervix and parametria. Although tumours of the rectum are as a rule operated on in this institution, good results have been obtained with radium treatment. Promising results are also expected with long half life isotopes, in particular cobalt 60 the half life period of which is 5.3 years.

At the Philadelphia University x-ray irradiation is practised, after plastic operations on the cornea, thus avoiding vascularization and resulting opacities

At the institute of Dr Stone in San Francisco radio-active phosphorus is used in the differential diagnosis between cancer of the breast and non malignant affections.

This method is exact in 80 / of the cases Iodine 131 which is useful for certain kinds of dysthyreosis has no practical value for the treatment of malignant tumours of the thyroid gland as its fixation in the tissues does not allow the application of sufficiently large doses without damaging other organs by gamma rays At this institute and in co-operation with the Radiation Laboratory at Berkeley the first experiments were made with irradiation by neutrons in cancer patients Because of variable results it is doubted whether this irradiation is sufficiently selective

In the United States radio active isotopes are now used in all physiological and pathological research work Betatrons of which there are now five in the United States with seven new apparatuses under construction or planned are not used for therapeutic purposes as the noise caused by magnetic oscillations makes treatment unbearable for patients

In certain institutions special instruments make it possible to check with precision the amount of irradiation to which personnel are submitted Working hours and the transfer of staff as well as holidays are established according to automatically tabulated results

Notes and News

Courses in Malariology

To operate a malaria-control programme such as has been recommended by the Expert Committee on Malaria countries taking part in the campaign need a specialized staff familiar with modern methods and having a thorough knowledge of scientific and technical matters In the report on its second session the expert committee thought it desirable that the training of directive professional staff should be carried out in special schools of malariology [1]

Among the malaria institutes already in existence where special courses might be organized are the Istituto di Malariologia Ettore Marchiafava and the Istituto Superiore di Sanità in Rome

Dr E J Pampana of the WHO Secretariat has recently visited Rome to arrange for collaboration between these two institutes in the organization of special courses in malariology As a result of the discussions a plan was drawn up for two different courses one in each of these institutes covering all aspects of malaria control

The Istituto di Malariologia Ettore Marchiafava would organize a course for foreign medical men from 22 May to 18 June with the following programme haematology morphology and biology of malaria parasites pathology of malaria and blackwater fever immunology clinical aspects of malaria antimalarial drugs therapeutics of malaria and blackwater fever epidemiology, history of malaria This course would be supplemented by practical laboratory and hospital work

At the Istituto Superiore di Sanità another course lasting two months would be given on Insect control as a public health measure The programme of this course would include medical entomology insect borne protozoa insect borne helminths chemistry and application of insecticides health statistics sanitary engineering organization of insect control by means of insecticid s

Ten days practical work would be carried out in the laboratory and in the field in Latina and Sardinia

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This latter course would be open to technical personnel employed in the control of diseases transmitted by flies sandflies and lice

These courses would be given in French, and would take place only if the numbers applying were sufficient.

Special Air Service for Antituberculosis Vaccines

Teams working in Europe under the international antituberculosis campaign carried out by several Scandinavian organizations with the technical assistance of WHO and with the material assistance of the United Nations International Children s Emergency Fund [2] (UNICEF) now receive BCG vaccines and other medical supplies by special aeroplane The new service started on 11 January 1949 when a C 47 aircraft carrying 2 500 kg of BCG tuberculin and other medical supplies made its first flight from Copenhagen to Belgrade where Scandinavian and Yugoslav vaccination teams are conducting an intensive campaign

The aircraft has been assigned free of charge by the American military authorities in Germany under a joint arrangement with UNICEF WHO and the Scandinavian authorities concerned Formerly a troop carrier it has been completely overhauled and fitted to fly in all weathers The aircraft is based on Copenhagen and will carry vaccines to Czechoslovakia, Greece Hungary Poland and other countries in which the antituberculosis campaign is being conducted. It is thus hoped to avoid the delays (due to weather conditions, changed schedules and other factors) which occurred when the vaccines were carried by commercial air lines They should now be delivered at a rate which will allow the teams to work without interruption

The ultimate object of the international antituberculosis campaign is to test approximately one hundred million children in all parts of the world and to inoculate with BCG vaccine those showing a negative reaction to the tuberculin test

Co-ordination of Medical Congresses

A conference will be held in Brussels from 4 to 9 April 1949 for the purpose of establishing a permanent bureau for the co-ordination of medical congresses Arrangements for this conference were made on 28 and 29 January in Paris at a meeting of representatives of the larger medical associations and of UNESCO and WHO who will sponsor the development of this new work of international collaboration

It will be remembered that at a previous meeting,[3] plans were discussed for the creation of a permanent bureau to collect information on medical organizations and on congresses organized by them, to co-ordinate such congresses, to give material assistance for their technical services and financial support for the publication and circulation of their proceedings The desirability was also expressed of making grants as far as possible to congress members who particularly merit them.

This initiative has been most favourably received by medical organizations throughout the world and more than 40 have announced their intention of taking part in the Brussels conference

The present executive committee will propose to the meeting the creation of a permanent council for the co-ordination of international congresses on medical sciences consisting of representatives of all member associations This permanent council would meet every three years, and in the intervals the work would be carried on by an executive committee of seven members. The administrative body of the permanent council would consist of a small secretariat headed by an executive secretary UNESCO

[2] Chron. W. Hl. h. O. 1949, 2, 59
[3] Chron. W. Hl. h. Org. 1948, 2, 63

and WHO intend to give their support to this new organization which gives promise of valuable service

During the recent meeting in Paris various proposals were made which will be submitted to the conference Among them may be mentioned a suggestion made by the WHO representative that in addition to normal congress debates lectures and demonstration courses on certain selected subjects be organized before or after congresses, so that the specialists may benefit from the presence of experts from all over the world

Uniform Designations in National Health Departments

A letter has been sent to governments by WHO asking them to state their views on the desirability of uniform designations for the chief executive officers of all national departments of health The letter was sent in compliance with a decision of the Executive Board at its second session

The Board suggested that the titles used by WHO might be adopted — namely

Director General of Health Deputy Directors General of Health and Directors

The Board further proposed that the chief executive officer should be responsible for the curative and preventive aspects of medicine whenever they are both the responsibility of a national government

Fellowships in Venereal Diseases

The State Serum Institute Copenhagen is to be available to WHO Fellows for training in the laboratory aspects of venereal diseases During a recent visit to Copenhagen of Dr T Guthe Secretary of the WHO Expert Committee on Venereal Infections, Dr J Örskov Director of the Institute agreed to accept Fellows for short periods of training in serology It is expected that Fellows will work in the Wassermann Division under Dr P Krag The period of training may vary from 3 to 4 weeks in some cases to as much as three months or even more Not more than two Fellows will work at the Institute at the same time

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VOL. 3, No 3

MARCH 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

MATERNAL AND CHILD HEALTH

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VOL. 3, No 3 MARCH 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

MATERNAL AND CHILD HEALTH

The first Health Assembly considered the protection of maternal and child health of such importance as to merit high priority in the programme of WHO activities [1] A special section of the Secretariat and an expert committee have therefore been established

This committee at its first session held in Geneva from 24 to 29 January 1949 [2] considered the various ways in which countries could usefully intensify their efforts for maternal and child welfare and to what degree WHO might extend its help to them

Help to Governments

In August 1948 a questionnaire was sent to governments asking them to give detailed information on maternal and child health services in their countries and to indicate what form of assistance they wished to receive from WHO Valuable information was sent by 39 governments and WHO was asked to grant fellowships to send experts and demonstration teams and to supply information on modern technique and various aspects of maternal and child welfare activity

Health Education Campaign

During discussion it was emphasized that to be effective any action should be based on well informed public opinion It therefore seems necessary that not only parents but also the public in general should be

[1] Chron. World Hlth Org 1948, 2, 170

[2] The following were present at this session

Members

Miss T K Adranvala, Chief Nursing Superintendent, Directorate General of Health Services, New Delhi, India

Dr I H Asia, Professor of Paediatrics, University of Istanbul, Turkey

Dr Martha M Eliot, Associate Chief Children's Bureau, Federal Security Agency Washington D C, USA (Chairman)

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Note — The *Chronicle of the World Health Organization* is published monthly in English, French, Russian, Spanish and Chinese. The *Chronicle* reports the activities of the Organization, without, however claiming to be an authoritative record of its official views, which are set out in the *Official Records of the World Health Organization*. All correspondence relating to it should be addressed to the World Health Organization, Palais des Nations, Geneva. Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom more especially in the medical Press, are entirely at liberty to do so.

Out of the funds transferred from UNRRA $1 000 000 was allocated in 1948 for implementing the programme discussed by the joint UNICEF/WHO committee In addition UNICEF has accepted the WHO proposal for organizing in the United Kingdom a course of training in maternal and child health for 50 people

FIG 1 FIRST SESSION OF THE EXPERT COMMITTEE ON MATERNAL AND CHILD HEALTH — I



Seated a o d tabl (clo kwi a) Mme Alantar Dr I H Al t D E Grzego zewski (WHO) D E Leppo (WHO) Dr Martha M El ot (Chairm) D Clc ly Wil ams (WHO) Mrs E Wiseman (WHO) Miss T K Ad an ala Dr Marion Ya g D Do othy M Taylor

Research

The committee considered that WHO could contribute to the co-ordination of scientific research undertaken in various parts of the world on subjects related to maternal and child welfare such as immunization against certain communicable diseases causes of morbidity and mortality among mothers and new born children rickets etc

Immunization

The committee noted various reports on the possibilities of immunization against certain diseases

Diphtheria Inoculation with diphtheria toxoid before the war was compulsory in only a few countries including Canada and the USA where it

informed and instructed in the care of children For this purpose, posters, the press radio and films might be used as well as the good offices of youth associations, women's clubs and similar organizations The committee recommended that governments be invited to develop this educational aspect in their public health programmes

Training of Personnel

The organization of a permanent long term project for maternal and child welfare such as is needed in many countries requires specialized personnel midwives, children s nurses and assistant staff At the present time there is a great lack of personnel in these professions It is most important that this state of affairs should be remedied by stimulating recruitment by perfecting the training of personnel and by improving working conditions and suggestions for achieving this were submitted to the committee It is most desirable that in the near future public health administrations should have at their disposal reasonably large staffs trained for social work and possessing general and technical knowledge in various branches of medicine including mental health which would allow them to accomplish the varied tasks implied in maternal and child welfare

Relations with Other Specialized Agencies

The committee was informed of the programme drawn up by the Joint Committee on Health Policy, UNICEF/WHO and also studied the measures recommended by UNICEF and by FAO for improving food conditions and in particular for increasing milk supplies to young children and lactating mothers

Members (continued)

Mme Y Feyerick Nevejan, Directeur général de l Œuvre nationale de l Enfance Brussels, Belgium
Dr Dorothy M Taylor Senior Medical Officer for Maternity and Child Welfare, Ministry of Health, London, United Kingdom
Dr Mar on Yang, Chief Division of Maternal and Child Health Ministry of Health Nanking, China (*Vice Chairman*)

Co-opted members

Mlle M Duvillard, Directrice de l Ecole d Infirmières du Bon Secours, Geneva Switzerland
Dr G Fanconi Professeur de Pédiatrie Directeur de l Hôpital pour enfants Zurich Switzerland
Dr Hanna Hirszfeld Professor of Paediatrics University of Wroclaw Poland

Secretaries

Dr Cicely Williams Secretariat WHO
Dr E Leppo Secretariat, WHO

The following persons also attended

Mrs M Fairchild Chief Women and Children Section, International Labour Organization, Geneva, Switzerland
Mrs. A Myrdal Principal Director Department of Social Affairs, United Nations Lake Success, N Y., USA
Mrs J M Small Chief Research Section International Union for Child Welfare Geneva Switzerland

Absent

Dr J Švejcar Professor of Paediatrics, University of Prague Czechoslovakia
Dr F Gómez, Director Children s Hospital Mexico City D F., Mexico

Mixed vaccines (multiple antigens) the use of which has been introduced in the course of the last few years have given good results They may be injected intramuscularly The following combinations are used diphtheria toxoid plus whooping cough vaccine diphtheria toxoid plus tetanus toxoid tetanus toxoid plus diphtheria toxoid plus whooping cough vaccine

The committee recommended that inoculation of children against communicable diseases be made part of the regular health programmes and that governments be requested to introduce compulsory inoculation against certain diseases particularly smallpox and diphtheria in countries where they are still prevalent

Yaws

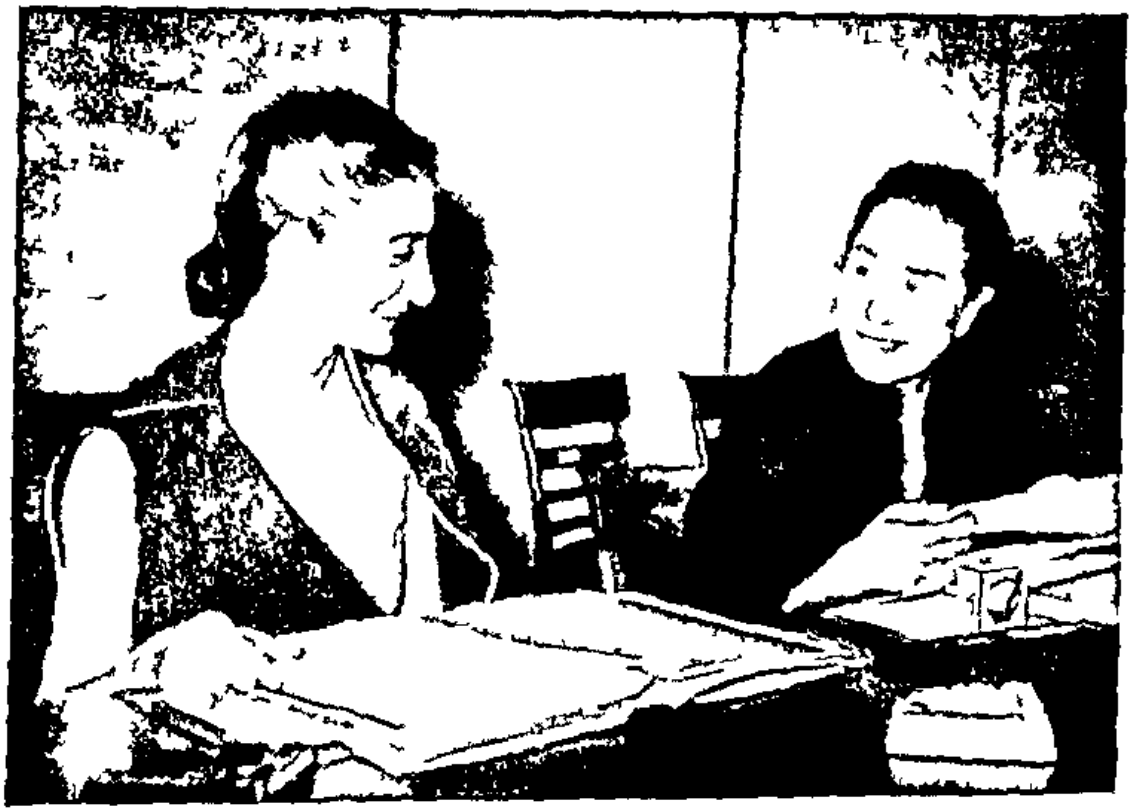
The committee noted a paper on yaws and its treatment with penicillin which stated that an investigation carried out in Jamaica had revealed that 90 % of infected persons were under 20 years of age and that the majority of them were children The lesions caused by yaws are easily recognized and their diagnosis is simple while penicillin has given excellent results in treatment the dosage and injection rates varying according to the age of the child The paper suggested that in countries where this disease caused ravages among the child population penicillin treatment carried out by specialized teams be undertaken and developed

Programme for Under Developed Countries

The committee discussed the organization of health services for maternal and child welfare in under-developed countries An active campaign should be undertaken in those countries where morbidity and mortality among mothers and children cause considerable human suffering and economic loss and where excessive infant morbidity results in a weakening of the physical and mental state of the population The final step would be the development of a specialized health service staffed by local personnel This personnel which would include nurses health inspectors and technicians should be trained through an international organization At the same time demonstrations should be instituted to show the population the usefulness of prophylactic and therapeutic measures for the reduction of mortality and morbidity among young children For instance in venereal diseases it should be easy to show that treatment of syphilitic pregnant women with penicillin helps to prevent stillbirth It is a known fact that in many countries the prospect of being able to give birth to live healthy children has already encouraged many syphilitic women to ask for treatment The authorities should provide in their final programme that maternal and child welfare services first organized in hospitals be extended to the homes of the people In this way public interest in these matters

resulted in a considerable decrease in diphtheria incidence, and, in some large cities, no deaths from this disease have been recorded during the past few years On the other hand, in Europe where inoculation is compulsory only in certain countries, diphtheria has been the main cause of infantile morbidity during the last ten years During the war, as a result of a vast pandemic 600,000 diphtheria cases and 150,000 deaths were notified in central and eastern Europe [3]

FIG 2 FIRST SESSION OF THE EXPERT COMMITTEE ON MATERNAL AND CHILD HEALTH — II



Left Miss T K Adranvala right Dr Marion Yang

Whooping cough Children in all parts of the world can contract this disease which now causes more deaths than does diphtheria in those countries where diphtheria inoculation is compulsory Preventive inoculation of young children against whooping cough is practised on a large scale at present only in the USA

Smallpox It is generally recognized that in countries where there are risks of an epidemic, all children should be vaccinated against smallpox during the first year of life Methods to be used and precautions to be observed have been dealt with in the report prepared by the Joint OIHP/WHO Study Group on Smallpox [4]

Ch on World Hlth O g 1947 1 153
16 / 1948 2 141

1928 [4] and the second World War only partly interrupted its activities which consisted in collecting and distributing epidemiological information especially during Mecca *pilgrimages* and in convening regional health conferences

FIG 3 WHO EASTERN MEDITERRANEAN REGIONAL CONFERENCE — 1



Openi g m eti g Left to right Dr N Ka abud (T key) Vi e-Chairm Mr H B ha (Pakista) Vi e-Ch i man Dr N Sca d r Pasha (Egypt) Chairma D Brock Chisholm D ctor Gene al, WHO

The Eastern Mediterranean region comprises the following countries Aden Anglo Egyptian Sudan British Somaliland Cyprus Egypt Ethiopia French Somaliland Iran Iraq Lebanon Pakistan Palestine Saudi Arabia Syria Transjordan Turkey Yemen and the former Italian colonies in Africa The new regional organization which has been established by the Cairo Conference comprises a Regional Committee representing all Member States situated in the area in question and an executive body the Regional Office which will begin operations on 1 July 1949 using the buildings which housed the former Sanitary Bureau at Alexandria The integration of the latter with the World Health Organization will thus be an accomplished fact Sir Aly Shousha Pasha Under Secretary of State Egyptian Ministry of Public Health and Chairman of the WHO Executive

F accou f the B re see *Off R W Id Hl h Org* 12, 65

should easily be aroused and collaboration obtained for the development of such services

The part played by WHO would be to assist governments to plan and set up these services which should eventually be maintained by the national authorities

Consideration by the Executive Board

The Executive Board at its third session considered the report of the expert committee and decided that, in presenting this report to the second Health Assembly certain comments should be added, which included the following recommendations that the Director General should be requested to approach governments directly for information as to their practices and views on immunization, that an international conference of experts on immunization procedures should be convened to discuss the use of the newer techniques for producing more effective vaccines, as well as plans for their widespread application in immunization programmes and that WHO should undertake a survey of all the work carried out in age groups most susceptible

EASTERN MEDITERRANEAN REGIONAL CONFERENCE

In accordance with the principles laid down in the WHO Constitution the first World Health Assembly decided to establish five regional organizations to deal with the particular health problems encountered in certain parts of the world [1]

The first regional conference held in New Delhi on 4 and 5 October 1948 laid the groundwork for the WHO regional organization for South East Asia [2] The Eastern Mediterranean Conference which took place in Cairo from 7 to 10 February 1949 [3] was the second regional conference convened by WHO

The Near East has a long tradition in international health matters and was served by the Egyptian Quarantine Board which under the International Sanitary Convention of 21 June 1926 acted as a regional bureau of the Office International d Hygiène Publique for epidemiological intelligence A Sanitary Bureau at Alexandria was subsequently set up in

[1] Chron. World Hlth Org. 1948, 2, 191
[2] Ibid. 1948, 2, 25
[3] Ibid. 1949, 3, 13. The list of delegates and observers who participated in this conference is to be found on page 5

the Director General, stated that the Organization s limited budget would permit the sending of only very small amounts of medical supplies in 1949 and 1950 but that, within the limits set by available funds all necessary steps would be taken to provide the help of experts and advisers in carrying out the health programmes contemplated by countries and to grant fellow ships for medical studies

FIG 5 WHO EASTERN MEDITERRANEAN REGIONAL CONFERENCE — III



Headquarters of the Ea te n Medit rra e n Regional Off ce at Ale a d ia

For the operation of the regional office during the first six months the Eastern Mediterranean Conference recommended a budget of $112 000 to cover administrative expenses and the cost of epidemiological notifications

Decisions of the Executive Board

At its third session the Executive Board of WHO approved in general the recommendations of the Cairo Conference The final choice of Alexandria as headquarters for the new regional office however is still subject to the approval of the United Nations During the discussion Sir Aly Shousha Pasha stated that Israel was not able to participate in the Cairo Conference as it is not yet a member of WHO but immediately following its adhesion to the World Health Organization this State would be welcomed by the new regional organization whose sole purpose would be to present an unbroken and united front against disease

Board, has been nominated Director of the Eastern Mediterranean Regional Office

During the conference all delegates successively reviewed the health situation in the countries or territories which they represented, and indicated the preventive and curative measures which have already been taken and the type of medical aid which they would like to receive from WHO

FIG 4 WHO EASTERN MEDITERRANEAN REGIONAL CONFERENCE — II



Opening meeting Left to right Mr H Bahar (Pakistan) Colonel M K Afridi (Pakistan) Dr N Karabuda (Turkey) Dr A M W Rae (United Kingdom) Médecin général M A Vaucel (France)

For climatic reasons, and because of the backward state of a large part of the population and of the lack of medical equipment health conditions in the region are very poor The principal diseases prevalent in this region are schistosomiasis, malaria, tuberculosis venereal diseases relapsing fever trachoma and typhoid fever Moreover the influx of refugees into countries bordering on Palestine and into Pakistan, following recent political and military developments, is causing special problems of a particularly urgent nature

The delegates of the governments concerned reported during the conference that they would need not only drugs such as penicillin and streptomycin, but also the help of medical experts and qualified advisers as well as fellowships In reply to requests submitted to WHO, Dr Chisholm,

the Director General stated that the Organization s limited budget would permit the sending of only very small amounts of medical supplies in 1949 and 1950 but that, within the limits set by available funds all necessary steps would be taken to provide the help of experts and advisers in carrying out the health programmes contemplated by countries and to grant fellow ships for medical studies

FIG 5 WHO EASTERN MEDITERRANEAN REGIONAL CONFERENCE — III



Headquarte s of the Eastern Mediterra ean Regio I Office at Alexand ia

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A second Eastern Mediterranean health conference will be held at Alexandria in October 1949

DELEGATES AND OBSERVERS PRESENT AT THE CONFERENCE

ANGLO-EGYPTIAN SUDAN	Dr H M Elliott Dr M A Nasr
EGYPT	Dr N Scander, Pasha, Dr M Nazif Bey Dr W Omar Sir Aly Tewfik Shousha, Pasha
ETHIOPIA	Mr W Endeshau Dr F B Hylander
FRANCE	Médecin Général Inspecteur M A Vaucel Dr J Helfet
IRAN	Dr M H Hafezi
IRAQ	Dr A H Toukhy
LEBANON	Dr T Haggar
PAKISTAN	Mr H Bahar Lieutenant Colonel M K. Afridi Mr G A Madani Colonel A K Sahibzada Professor M A H Siddiqi
SAUDI ARABIA	Dr R Pharaon Dr M Khashokji
SYRIA	Mr N Shehab
TURKEY	Dr N Karabuda
UNITED KINGDOM	Dr A. M W Rae Mr T F Anderson Dr M S W Bisdee Dr M R Burke Dr E Cochrane Dr C H Howat, Dr A E. Lorenzen Dr E. D Pridie Dr C. J Radway
FAO	Dr M A Abbassy Mr K A Bennett, M T Hefnawi Pasha Count A Knuth
ICAO	Mr D Lefèvre
ILO	Dr R Boutros
UNESCO	Mr L. Thuriaux
UNITED NATIONS	Mr J Keen

The delegates of France and the United Kingdom represented those territories for the conduct of whose international relations they are responsible

PENICILLIN PRODUCTION IN EUROPE

The health rehabilitation of Europe depends to a great extent on the possibility of obtaining drugs as was shown during discussions which took place at the European Health Conference in November 1948 [1] In particular large quantities of penicillin are indispensable in order to carry out adequately the large scale campaigns against venereal diseases which have been undertaken in many countries However the difficulty in obtaining this antibiotic constitutes a serious obstacle in the development of certain health programmes For this reason WHO which is continuing the work of UNRRA in this field [2] has in conjunction with the Economic Commission for Europe (ECE) examined the economic aspects of the problem of penicillin production in Europe

Geneva Conference

In certain countries in particular in Byelorussia Czechoslovakia Poland the Ukraine and Yugoslavia UNRRA had installed penicillin plants the equipment of which is at present incomplete or out of date A conference was called by WHO to study how these plants could be put into operation The governments of the five countries had been invited to send representatives to the meeting held in Geneva on 17 and 18 February 1949 [3] which was also attended by outstanding experts in penicillin and its production

Future Possibilities

An exchange of views on the technical and economic aspects of the question brought the following points to light

Chron World Hl h Org 1948 2, 275

Ibid. 1948 2, 185

The f ll wing w re p esent at the meeti g

C h l akia

D E. U gár Ministerial Counsell Ministry of Public H alth, Prague
Dr V Skola, D rect Penicillin Plant

Poland

Dr T Korzybski, Penicilli Producti n Dep rtment, State In tut f Hygiene, Warsaw
Dr W Kurylo icz, Penicillin Productio Dep rtment, State Inst tute f Hygiene W rs w
M W G m lka, Direct P nicilli Plant

Y g slavia

D M Plantanida, Chief State Pharmaceutical F ct ry Zagreb
D D Tamburase Chief Departme t of B cteriology Penicillin Plant

Expe t

M E. B Cham, University Demons rator and Lect rer in Chemical P thology University of Oxford United Kingdom Visiti g Professor Is to S periore d Sanità, Rome, Italy
D E. K ding, Leo Pharmace cal Products, Copenh gen, Denmark
M C Treschow Leo Pharmace tical Products, Copenhagen, Denma k

ECE

M E W ssm nn, Direct I dustry and Materials D visio
M D J Le cock Enginee I d try and M ri l D vision

WHO

Dr N D Begg, Actung Chief Special Office for Europe

It would be possible by supplying missing equipment, to put the Polish and Czechoslovak plants into operation for the purpose of producing amorphous penicillin, for which they were designed But this solution would probably be uneconomic The plant in Yugoslavia would have to be entirely re equipped as its present equipment was inadequate

The production of crystalline penicillin would require the reorganization of the plants along new lines and the replacement and supply of a certain quantity of industrial equipment Nevertheless this solution seemed to be both simpler and more economical and it was decided to carry it out while leaving Poland and Czechoslovakia free to use their plants for the production of amorphous penicillin

In carrying out these projects, it would be possible to increase the production of penicillin in Europe Such increased production, however, could not be achieved on a competitive commercial basis According to expert opinion the daily production of 1,000 mega units of pure crystalline penicillin G sodium salt from 10 000 litres of broth can be considered as satisfactory for factories of this type when beginning operations

The equipment of factories for the manufacture of crystalline penicillin G sodium salt requires machinery of which certain important parts are obtainable only in the USA During the discussion, it was repeatedly pointed out that the most useful service which WHO and ECE could render to the countries concerned would be to facilitate steps for the importing of such materials, as difficulties are sometimes encountered in this connexion The representatives of Czechoslovakia, Poland and Yugoslavia also requested that WHO supply detailed information on the price and available stocks of materials required not only for putting UNRRA plants into operation but also for the equipment of new ones whose construction might be contemplated Moreover it was felt that there should be the closest possible collaboration between the three countries for the joint equipment of their factories

The representatives of Poland Czechoslovakia and Yugoslavia stressed the advantages to be gained in the future from the establishment by WHO of a co operative centre for technical training and research in antibiotics in general In this way, the interest of countries in penicillin production would also be stimulated

Results of the Conference

These consultations have shown that the three countries in which UNRRA penicillin plants are installed are determined to undertake the production of penicillin without delay, by every means at their disposal, and to work together to obtain technical information and materials According to expert opinion such an endeavour is most justifiable as it is hardly probable

that in the near future important changes will be introduced in the present methods of penicillin manufacture

Consideration of the Question by the Executive Board

At its third session which has just taken place in Geneva the Executive Board considered the recommendations made by the Conference In connexion with the activities of the special office for Europe it approved the action taken by the Director General to procure on behalf of the three countries concerned a certain amount of equipment and material from the United States Subject to the approval of the Joint Committee on Health Policy UNICEF/WHO the Board also authorized the Director General to advance sums not to exceed $100 000 from the special UNRRA Fund for this purpose These sums will be reimbursed by the States Members concerned

MEDICAL CARE OF MIGRANTS

Of great interest today is the problem of migration Attempts to solve outstanding labour problems so directly influencing world economy will undoubtedly result for many years to come in important population movements throughout the world

The repercussions which such movements have on the health of individual migrants as well as on health conditions in immigration countries are obvious and it should be recalled that foci of epidemic and even pestilential diseases are often the result of migratory movements It is therefore essential for international regulations to make provision for limiting if not for obviating the dangers inherent in migration

The conditions under which such migration should take place are clearly laid down in an international convention drawn up in 1939 the revision of which has recently been undertaken by the Permanent Migration Committee which met in Geneva at the International Labour Office from 13 to 27 January 1949 and to which WHO was invited to send a representative

The texts submitted for examination contained recommendations regarding the medical care of migrants but these appeared only in the model agreement which had no mandatory character and not in the convention itself and therefore remained entirely optional

As a result of proposals put forward by the WHO representative the Permanent Committee agreed to include health provisions in the convention itself The committee in fact was of the opinion that both from the humanitarian and social viewpoints it was essential that the health of

migrants should be protected It was agreed that it was to the individual advantage of both emigration and immigration countries that transferred workers should be and should remain, in good health, as otherwise such workers might possibly have to be sent back to their own countries or might even spread disease in immigration countries thereby occasioning hospitalization and treatment expenses The committee also recognized that it would be illogical for countries which had signed international sanitary conventions for the prevention of epidemic diseases to refuse to include similar provisions in a migration convention

Finally, the committee considered that if measures which are indispensable to the health of migrants were not clearly laid down and strictly adhered to the mass movement of migrants might lead to the creation of epidemic foci If this happened, the normal application of international sanitary conventions at present in force would automatically bring to an immediate stop all migratory movements over an entire region for an indefinite period

From the viewpoint of health, the importance of the decisions taken by the Permanent Migration Committee will thus readily be seen It is gratifying to note moreover the results of the widening scope of the ever closer collaboration between ILO and WHO, thus increasing the usefulness of co ordination between specialized agencies of the United Nations

USSR, THE UKRAINIAN SSR, AND THE BYELORUSSIAN SSR ANNOUNCE INTENTION TO WITHDRAW FROM WHO

The Director General of WHO received on 12 February the following telegram from the USSR and a similar cable from the Ukrainian SSR [1]

I HAVE THE HONOUR TO INFORM YOU THAT THE HEALTH MINISTRY OF THE USSR AND THE MEDICAL INSTITUTIONS AND ORGANIZATIONS UNDER IT ARE NOT SATISFIED WITH THE WORK OF THE WORLD HEALTH ORGANIZATION STOP TASKS CONNECTED WITH INTERNATIONAL MEASURES FOR PREVENTION AND CONTROL OF DISEASES AND WITH THE SPREAD OF MEDICAL SCIENCE ACHIEVEMENTS ARE NOT BEING ACCOMPLISHED BY THE ORGANIZATION SATISFACTORILY STOP AT THE SAME TIME MAINTENANCE OF THE ORGANIZATION S SWOLLEN ADMINISTRATIVE MACHINERY INVOLVES EXPENSES WHICH ARE TOO HEAVY FOR MEMBER STATES TO BEAR STOP ALL THIS SHOWS THAT THE DIRECTION TAKEN BY THE ACTIVITIES OF THE ORGANIZATION DOES NOT CORRESPOND TO THOSE TASKS WHICH WERE SET

[1] A similar cable was received on 14 February from the Byelorussian SSR

BEFORE IT IN 1946 AT THE INAUGURAL CONFERENCE OF THE ORGANIZATION STOP IN VIEW OF THE ABOVE THE UNION OF SOVIET SOCIALIST REPUBLICS NO LONGER CONSIDERS ITSELF A MEMBER OF THIS ORGANIZATION YOURS ETCETERA VINOGRADOV DEPUTY MINISTER OF PUBLIC HEALTH OF THE USSR

The Director General of WHO replied as follows to the USSR and with suitable variations to the Ukrainian SSR and the Byelorussian SSR

YOUR CABLE 455 OF TWELFTH FEBRUARY RECEIVED WITH REGRET STOP BECAUSE CONSTITUTION OF WHO MAKES NO SUCH PROVISION I CANNOT ACCEPT YOUR COMMUNICATION AS A WITHDRAWAL FROM THE ORGANIZATION STOP YOUR COMMUNICATION WILL BE SUBMITTED TO THIRD SESSION OF EXECUTIVE BOARD OPENING HERE TWENTY FIRST FEBRUARY STOP ARTICLE TWENTY EIGHT PROVIDES THAT EXECUTIVE BOARD SHALL GIVE EFFECT TO DECISIONS AND POLICIES ESTABLISHED BY HEALTH ASSEMBLY AND MAY SUBMIT ADVICE OR PROPOSALS TO THE ASSEMBLY STOP MOST ADVISABLE YOU SHOULD BE PRESENT AT THIS SESSION IN ORDER TO PRESENT YOUR VIEWS ON EXECUTION AND ADMINISTRATION OF THE PROGRAMME STOP IT IS CONSIDERED PREMATURE TO HAVE EXPRESSED DISSATISFACTION WITH IMPLEMENTATION OF AIMS OF CONSTITUTION BY WHO AFTER ONLY FOUR MONTHS OF ORGANIZATIONAL WORK IN 1948 AND A FEW WEEKS OF 1949 WHO IS ONLY NOW EMERGING FROM ORGANIZATIONAL PERIOD STOP FIRST YEAR PROGRAMME FOR 1949 IS NOW OPERATING WITHIN LIMITS PRESCRIBED BY FIRST HEALTH ASSEMBLY STOP PROPOSED PROGRAMME FOR 1950 TO BE DISCUSSED AT THIRD SESSION EXECUTIVE BOARD PROVIDES FOR LARGE SCALE CONTROL OF EPIDEMICS BY ERADICATION AND EXTENSIVE STRENGTHENING OF NATIONAL HEALTH ADMINISTRATION WHICH WOULD MEET YOUR POINT OF VIEW STOP YOUR ADVICE ON THIS PROGRAMME HIGHLY DESIRABLE YOUR PARTICIPATION IN BOARD MEETING IS ESSENTIAL AND I PROPOSE THAT I VISIT MOSCOW FOR FULLER DISCUSSIONS IMMEDIATELY AFTER EXECUTIVE BOARD IN EARLY MARCH STOP SIGNED CHISHOLM

The Executive Board discussed the matter at its third session held in Geneva recently and the following telegram was sent to the competent authorities of the USSR, and with suitable variations to the Ukrainian SSR and the Byelorussian SSR

THE EXECUTIVE BOARD OF THE WORLD HEALTH ORGANIZATION NOW IN SESSION NOTES WITH REGRET THE CHANGE IN YOUR ATTITUDE TOWARDS WHO AND STATES ITS BELIEF THAT THE SCOPE AND QUALITY OF THE WORK ACCOMPLISHED BY WHO IN THE SHORT PERIOD OF ITS EXISTENCE IS SUCH AS TO INSPIRE THE CONFIDENCE OF ALL MEMBER STATES IN ITS IMPLEMENTATION OF THE OBJECTIVES OF THE CONSTITUTION STOP THE BOARD CALLS ATTENTION TO THE ABSENCE OF THE MEMBERS FROM USSR AND BYELORUSSIA FROM ITS SECOND SESSION WHICH MAY HAVE LED TO POSSIBLE MISUNDER

STANDING STOP THE BOARD REQUESTS ME TO SOLICIT YOUR CONTINUED SUPPORT WHICH WOULD PREVENT DAMAGE TO VALUABLE WORK AND INTERNATIONAL HEALTH STOP BOARD WILL REFER THIS MATTER TO THE SECOND HEALTH ASSEMBLY STOP I WISH TO HAVE YOUR INVITATION TO VISIT MOSCOW ALONG WITH THE DIRECTOR GENERAL IMMEDIATELY AFTER CLOSE OF THIS SESSION OF BOARD IN ORDER THAT THIS MATTER MAY BE PROPERLY DISCUSSED SIR ALY TEWFIK SHOUSHA PASHA CHAIRMAN EXECUTIVE BOARD "

It will be recalled that the Byelorussian SSR, the Ukrainian SSR and the USSR participated in the International Health Conference held in New York in June July 1946 and that delegates of the three States were among the founders of the Organization who signed its Constitution on the historic day of 22 July 1946 [2]

Representatives from the USSR and the Ukrainian SSR were elected to serve on the Interim Commission, which was established to assume, until the entry into force of the Constitution the responsibility and the tasks which now devolve on WHO [3] The USSR representative partici pated in all five sessions of the Commission and the Ukrainian representative in two Dr F G Krotkov, Deputy Minister of Public Health, Moscow who had been a Vice President of the International Health Conference was unanimously elected Chairman of the Interim Commission Dr Krotkov agreed to serve as Chairman during the first session but declined permanent acceptance of the honour conferred upon him in view of his return to Moscow [4]

The Constitution of WHO was ratified by the USSR the Byelorussian SSR and the Ukrainian SSR in April 1948, and delegates participated in the first World Health Assembly held in Geneva in June July 1948 [5]

The USSR and the Byelorussian SSR were elected to designate persons to serve on the Executive Board for periods of two and three years respec tively these members were present at its first session [6]

[2] *Chron World Hlth Org* 1947 1 7 41
[3] *Ibid* 1947 1 10
[4] *Ibid* 1947 1 44
[5] *Ibid* 1948 2, 210
[6] *Ibid* 1948 2, 169

SCHISTOSOMIASIS

Schistosomiasis which according to certain estimates affects 150 million people incapacitates many for work and causes considerable economic loss throughout the world

The first World Health Assembly gave a third rank priority to several parasitic diseases suggesting that schistosomiasis should be the first object of study[1] In a recent article in the *Bulletin of the World Health Organization*[2] Sir Aly Shousha Pasha after briefly outlining the problem in general describes the principles and methods of control which have been successfully employed in Egypt during the last few years

It is well known that the geographical distribution of schistosomiasis throughout the world is determined by the presence of molluscs which act as intermediate hosts for trematodes Practically the entire continent of Africa is infested as well as countries in both hemispheres situated between latitudes 38°N and 35°S there being however certain areas between these latitudes which are free from parasites Certain schistosomes (*Schistosoma haematobium* in particular) are specific parasites of the urogenital system others (*S mansoni S japonicum*) settle in the digestive system They give rise to pathological conditions in various organs through the toxic substances which they excrete and the eggs which they deposit The clinical picture of the disease is marked by anaemia, under-development, asthenia and general debility and the prognosis is often fatal.

So far the only remedy which has proved successful is potassium antimony tartrate treatment with which was introduced into Egypt in 1919 Annexes were instituted in various provincial hospitals and in 1928 a special section of the Ministry of Public Health was entrusted with the supervision of anthelmintic units In 1924 a uniform method of cure registration was adopted Treatment has been carried out on a growing scale and the cases treated increased from 46 945 in 1924 to 388 485 in 1945 In 1941 treatment was made compulsory Mobile units were established for examination and treatment in villages far from important centres In the future units will be provided with beds for markedly anaemic or debilitated patients

In Egypt the number and severity of surgical complications have greatly diminished as a result of the extensive application of the treatment the incidence of such complications dropping from 50 per 10 000 cases in 1925 to 2 per 10 000 in 1933 The potassium antimony tartrate treatment which causes considerable discomfort, is dreaded by patients Shousha Pasha emphasizes the advantage which would be derived from an effective

Chron World Hl h Org 1948, 2, 180
Bull World Hl h Org 1949 2, 19

drug capable of being injected intramuscularly or hypodermically and which would be easily tolerated by the patients

Treatment must be accompanied by prophylactic measures, for the former alone cannot possibly eradicate the disease, which is spreading to parts of the country which have been opened up to irrigation The only method of eradicating the disease would seem to be destruction of the molluscs which are the intermediate hosts of schistosomes In 1940 the Egyptian Ministry of Public Health with the help of the Rockefeller Foundation instituted a special snail destruction section This section has grown into a department with a large organization operating in over 320 permanent centres and employing 10 000 workers and staff Different methods of control in the field have been tried

1 Clearance of infested water courses of their weeds and snails Clearing is done by means of hoes, while nets are used for removing molluscs and plant refuse

2 Drying of canals for periods of ten days to one month is not effective, as snails survive drying

3 The canal alternation system which entails the digging of a canal alongside an existing canal, the earth dug out of the new one being thrown into the old has also been tried

4 Underground irrigation carried out on an experimental basis furnished excellent results The initial cost would be considerable but in a few years could be compensated by returns

Copper sulphate was chosen as the snail poison having the fewest drawbacks It is a potent molluscicide, even in very small concentrations

Snail control has already proved its worth in Egypt Shousha Pasha, gives the example of the province of Fayûm in which 25 % of the water courses were infested with snails After four years of control work, only 2 % were still infested while during the same period the number of snails collected in infested streams dropped from 63 to 5 snails per 100 dips

In the same issue of the *Bulletin*[3] J A Meira supplies information, together with a map, on the distribution of schistosomiasis in Brazil Recent surveys carried out in that country which has for a long time been considered free from the disease have shown that schistosomiasis is highly prevalent in most of the provinces surveyed although available data do not make it possible to depict accurately the extent of the disease throughout the country According to the author the incidence rate may be roughly estimated at 6 2 % of the population (indicating nearly 3 000 000 persons infected), this percentage being probably lower than the real rate The surveys made in Brazil lend weight to the belief that the extent of the

[3] *Bull World Hlth Org* 1949 2 31

distribution of schistosomiasis has not hitherto been sufficiently realized In 1947 a bill was presented to the Brazilian Congress providing for the creation of a national schistosomiasis service in the Public Health Department of the Ministry of Education and Health

PARACHOLERA (EL TOR)

Enteritis Choleriformis El Tor van Loghem

Carriers of vibrios are regularly found among the pilgrims returning from Mecca examined at the El Tor quarantine station on the Sinai Peninsula These El Tor vibrios which closely resemble cholera vibrios do not cause cholera, but a vibrio of the E l Tor type has been found to cause cholera like disease on the island of Celebes in Indonesia In its clinical aspects this disease is not distinguishable from Asiatic cholera and has a high case fatality rate A detailed study by Dr C E. de Moor of the Makassar Public Health Laboratory on the development of the disease from 1937 to 1944 has recently been published in the *Bulletin of the World Health Organi ation*[1]

From the bacteriological analysis of vibrios from 370 sources originating from patients carriers wells and rivers Dr de Moor demonstrated that the organism in question was a true El Tor vibrio belonging to the Gardner and Venkatraman O I group Haemolysis in blood broth within 24 hours growth positive Greig s test with broth culture and beta haemolysis on anaerobically incubated blood agar are reliable criteria for the identification of newly isolated strains Other tests make it possible to differentiate between the El Tor and the cholera vibrio soda serum agglutination (dilution of strong cholera O serum with 0 3 % Na_2CO_3 2 H_2O adding a suspension of vibrios in distilled water positive with El Tor vibrios negative with cholera vibrios) and the soda sublimate precipitation (suspension of vibrios in 0 5 / $NaHCO_3$ with the addition of an equal volume of 0 5 % HgCl. negative with El Tor vibrios positive with cholera vibrios)

In the second part of his study the author describes the phases of the disease on the island of Celebes during successive outbreaks appearing from 1937 to 1944 stressing the essential epidemiological differences between cholera and the disease caused by the El Tor vibrio

Cholera is a parasitic infection epidemic by nature and is caused by a vibrio of extrem virulence The El Tor vibrio on the other hand is occasionally pathogenic and causes only slight morbidity The disease is not of a typically epidemic nature but is characterized by sporadic cases appearing successively or simultaneously but without apparent connexion

between them While a single infection with cholera vibrios of the drinking water reservoirs of Hamburg or the Broad Street pump in London, caused catastrophes in the past, infection with El Tor vibrios of all the drinking water wells used by the inhabitants of a kampong (native village) on the island of Celebes had no untoward effects Polluted wells and vibrio carriers have been detected in villages where no outbreaks occurred

These epidemiological differences between cholera and the El Tor disease are sufficiently important to warrant a distinctive diagnostic term for each disease Through analogy with the nomenclature of the various fevers of the typhoid group, the author proposes to call the disease caused by the El Tor vibrio in Celebes "paracholera (El Tor) Professor van Loghem had previously suggested that it be called "enteritis choleriformis El Tor According to Dr de Moor, there is no necessity for quarantine measures but, as long as there is no general agreement on the identification of the El Tor vibrio official international notification will be necessary

SPECIFIC ANTIGEN OF CHOLERA VIBRIO

Complete Analysis and Practical Applications

Dr J Gallut of the Institut Pasteur, Paris has made an exhaustive analytical study of the heat stable antigen of the cholera vibrio (specific O antigen), and his findings have recently been published in the *Bulletin of the World Health Organization*[1] Confirming research work carried out by Burrows, the author notes that a greater number of O antigenic factors exists in cholera vibrios than has so far been admitted As many as 13 antigenic factors (A, B, C M) can be detected This discovery is very important as it may enable the accuracy of the serological diagnosis of cholera to be increased, and vaccines to be prepared in such a way as to be better adapted to the various epidemics

The author analysed 82 strains which fall into two groups the first comprising 61 so called "agglutinable' vibrios and the second comprising 21 so called 'inagglutinable vibrios Following the usual serological diagnosis, the 61 "agglutinable vibrios were classified as follows 2 Ogawa 40 Inaba 18 Hikojima and 1 atypical Complete antigenic analysis however, revealed their multiple O factor content and showed the antigenic differences which may appear between vibrios considered as serologically identical Antigenic analysis of the second group revealed the presence, in some of the vibrios, of factors found in the first group Moreover there are frequency variations in the distribution of these factors which indicate an essential point factor A which is to be found in all

[1] *Bull World Hlth Org* 1949 2 39

agglutinable vibrios has never been found in inagglutinable vibrios For this reason the author is in a position to state in agreement with Burrows that antigen A is the only specific antigen of the authentic cholera vibrio (and of the El Tor vibrio which is serologically identical) Expe rience has also shown that factor A can exist alone thus making it possible to define a new and fourth type of cholera vibrio Factors B and C are essential as they are specific for the Ogawa (B) and Inaba (C) types but only in a subsidiary way because of their relationship with factor A Factors B and C were in fact encountered more frequently in non-cholera vibrios Factors D E M are of less significance The O antigenic formulae of the agglutinable" vibrios and the frequency of O antigenic factors in both groups of vibrios are summarized in two tables

These experiments may have important practical consequences

(*a*) In diagnosis anti O monospecific serum A will have to be used in future in preference to Ogawa and Inaba sera which are prepared from strains of which the antigenic formula is only partially known Agglutina tion due to non specific factors will thus be avoided

(*b*) Complete antigenic analysis of the cholera vibrio may change present views on the preparation of vaccines In this respect, too the accepted conception of the Ogawa Inaba and Hikojima types now seems outmoded If the need arises of using a so-called monovalent vaccine to combat an epidemic of a supposedly single serological type [2] it would be advis able to proceed with the greatest possible care and not rely too much on the respective monospecificity of the three classical types

Antigenic analysis showed that Egyptian cholera vibrios of the 1947 epidemic nearly all of the Inaba type contained all the factors except B G and J with factors A C D E and L predominating For this reason Dr Gallut is of the opinion that not only does a mixed vaccine composed of one Ogawa and one Inaba strain appear to be inadequate but a vaccine composed of the Inaba type alone might be partially ineffective if it contained only the two factors A and C specific for this type and none of the sub-sidiary factors According to the author the solution so far adopted of preparing vaccine from strains isolated during the epidemic against which control measures are being taken lacks precision If the overriding necessity of having a completely polyvalent vaccine in stock comprising the 13 O factors is admitted it would seem logical to take into account the antigenic composition of the vibrios responsible either for endemic cases or a specified epidemic Moreover it would be advisable to make a selection from those strains containing all the required factors by quantitative titration of the total O antigenic content of each one thereby ensuring the production of a vaccine with maximum specific immunizing properties

Chron. World Hlth Org 1948 2, 117

STAPHYLOCOCCUS TOXOID

Standardization of Methods of Assay and Test

The standardization of staphylococcus toxoid gives rise to various problems of a technical nature regarding the choice of methods of assaying and testing. In an article which has been published in the *Bulletin of the World Health Organization*,[1] P. Mercier & J. Pillet of the Institut Pasteur, Annexe de Garches, discuss these problems and give a clear indication of the methods employed in France for these various tests.

The international standard for staphylococcus antitoxin α which was adopted in 1934 by the Permanent Commission on Biological Standardization of the League of Nations, has given satisfactory results. However, the titre of the same sample of staphylococcus antitoxin was sometimes observed to vary with the method of titration employed for comparison with the international antitoxin. Research carried out by Llewellyn Smith has furnished an explanation of these discrepancies and has led to the production of a new international standard for antitoxin α, with which the titration of toxins, antitoxins and toxoids can be carried out with great precision.

After describing the possible inaccuracies which may arise from the estimation of the toxic titre in terms of partial haemolysis as recommended by several laboratories, the authors give an account of the various methods employed in different countries in the assaying and testing of the toxoid. Then follows a description of the methods adopted in their laboratory. The antigenic potency of the toxoid is estimated by an animal test (guinea pig) and by the combining power. These two tests, in vitro and in vivo, seem necessary in order to ensure more precise results, as both methods have their advantages and disadvantages. To determine the immunizing powers of toxoid in animals is a long and costly process, involving differences from one animal species to another. Regarding combining power, experiments carried out by the authors since 1934 have enabled them to appraise the close relationship between combining power and immunizing potency in man. However, this test can give rise to a few errors attributable to haemolytic irregularities. Flocculation should be a standard method for determining the antigenic potency of toxoid, but has some disadvantages, in particular that of furnishing less accurate results with antigen purified by trichloracetic acid than with crude toxoid.

After pointing out that in the various laboratories where staphylococcus toxoid is prepared checking methods are more uniform than tests for immunizing power, the authors give a detailed account of the methods which they use when testing for sterility and the disappearance of skin necrotic activity.

[1] *Bull. World Hlth. Org.* 1949, 2, 43.

On the basis of a long experience the writers state that at present the potency of a toxoid can be tested with precision when measured by its combining power and by its immunizing properties on animals nd it is their hope that an international agreement will define the require .. to which staphylococcus toxoid should conform

BULLETIN OF THE WORLD HEALTH ORGANIZATION

Volume 2, number 1 of the *Bulletin of the World Health Organi..ation* is now in press, and contains the following articles

Paracholera (El Tor) enteritis cholerıformis El Tor van Loghem — *C E de Moor*

Schistosomiasis (bilharziasis) a world problem — *Sir Aly Tewfik Shousha Pasha*

Schistosomiasis mansoni a survey of its distribution in Brazil — *João Alves Meira*

Complete analysis of the specific antigen of the cholera vibrio and its practical applications — *J Gallut*

On the standardization of the methods of assaying and testing staphylococcus toxoid — *P Mere er & J Pillet*

On standardization of diphtheria toxoid some theoretical and practical considera tions — *N K Jerne & O Maaloe*

Tetanus toxin and antitoxin — *Depa tment of Biological Standards National Ins titute for Medical Resea ch London*

Dextro-tubocurarine chloride a provisional British standard — *Department of B ological Standards National Institute for Medical Resea ch London*

Standardization of the cobra *(Naja flava)* antibody a comparative study by the method of assay at various levels and by the selected antivenene single level method — *E Grasset*

Venereal diseases in Ethiopia survey and recommendations — *T Guthe*

International control of venereal disease excerpts from the report on th second session of the Exp rt Committee on Venereal Diseases

Some of these articles have been noticed in this number of the *Chron cle* notices of others will appear in the following number

The *Bullet n* is published quarterly in separate editions in English and Fren h The price per single copy is 7/6 or ~1.50 and the subscription for 1949 is 30/ or ~6 Orders may be sent to the booksellers listed on the back cover of the *Cl onicle* or direct to the World Health Organization Sales Section Palais des Nations, Geneva, Switzerland

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves Selections from these reports will therefore be published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows

Organization of the Anti Poliomyelitis Campaign in the United States

Dr D Battini expert on poliomyelitis and on maternal and child health in Rome has spent four months in the United States studying the organi ation of poliomyelitis control

For the past few years poliomyelitis has been considered a disease of national importance by health authorities and the general public in the United States Institutions state services and foundations with considerable means at their disposal are uniting their efforts in order to carry out a large scale prophylactic and therapeutic programme

The main work is divided between official health authorities and the National Foundation for Infantile Paralysis founded in 1938 by F D Roosevelt The Foundation carries on its work in more than 3 000 counties through its executive branches called chapters whose function is to direct standardize co ordinate and carry out all research on the cause and nature of poliomyelitis as well as on the means of preventing and combating the disease The Foundation has large sums at its disposal which it uses for various purposes scientific research on the virus and on the prophylaxis of the disease the mode of transmission of which is not yet clearly known education of the general public and upkeep of the Warm Springs Institute Georgia which plays a very important role especially with regard to the training of specialized personnel and the study of methods of treatment at various stages of the disease The institute is in touch with outstanding specialists in the USA It should be noted that these experts as well as the greater part of the personnel of the Foundation s chapters give their services voluntarily On the other hand the Children s Bureau in Washington extends its help to all state services dealing with crippled children in order to encourage the authorities to develop services

On his return from the United States Dr Battini was entrusted with the inspection of treatment centres for poliomyelitis in Italy and is making plans for developing the control of this disease in his country according to the principles which he had seen applied in the United States The new organization should according to Dr Battini be supported by a well informed public opinion aware of the dangers inherent in poliomyelitis and of the necessity of reporting cases whether confirmed or doubtful immediately following their appearance Doctors themselves should be kept abreast of the present possibilities of early treatment of cure and of reducing the gravity of complications Regarding practical measures to be taken better hospitalization conditions will be required so that the disease may be treated from the earliest stages and the diagnosis of doubtful cases verified Provision will have to be made for the establishment of a few perfectly equipped centres and for the improvement of existing ones while at the same time closing down

those which no longer meet modern requirements. Each centre should comprise the following isolation facilities a laboratory for diagnosis and scientific research facilities for treatment during the acute phase of the disease provision for various types of physiotherapy and for occupational therapy a prosthetic laboratory and orthopaedic apparatus facilities for propaganda and education, and for the training of personnel.

The difficulties encountered are of a technical rather than financial nature as it is above all important to form a nucleus of trained personnel. A new organization carried out on rational lines would not increase present state expenses for aid to cripples It would be advisable to stipulate that only officially recognized centres meeting the above mentioned requirements would be authorized to treat poliomyelitis cases at state expense Precise checking of therapeutic methods and results obtained would thus be possible

The implementation of this programme would also entail the training of medical and nursing personnel by means of fellowships for study abroad and of regular courses in national centres An intensive propaganda campaign on poliomyelitis should be initiated for the general public

Notes and News

Health of the Palestine Refugees

A recent investigation made by Dr J D Cottrell WHO representative with the United Nations Relief for Palestine Refugees (UNRPR) showed that smallpox was probably the most dangerous epidemic threat among the 600 000 to 800 000 refugees in camps and villages scattered throughout Lebanon Transjordan Syria and Palestine Although the mortality among the refugees was not high, except in certain isolated areas steps were nevertheless taken for the re-vaccination of all refugees The American University at Beirut is expected to supply vaccine at a very low cost.

Medical supplies in that area are scarce but the situation is gradually improving WHO has contributed $50 000 to be spent on sanitation and preventive medical services and UNICEF has contributed a further sum of $150 000

The main diseases prevailing in the area visited by Dr Cottrell are malaria, measles, dysentery respiratory infections skin diseases and some enteric fever A WHO malaria engineer is now making a malaria survey of the entire area, accompanied by Dr K. Krikorian, formerly Deputy Director of Public Health for the Palestine Government, who is acting as WHO temporary public health consultant It is believed that, except for those in a few dry areas all the refugees can be considered as living in potentially malarial zones Tentative plans were therefore being made although details would await the report of the WHO malaria engineer to carry out DDT residual spraying in all camps and some villages

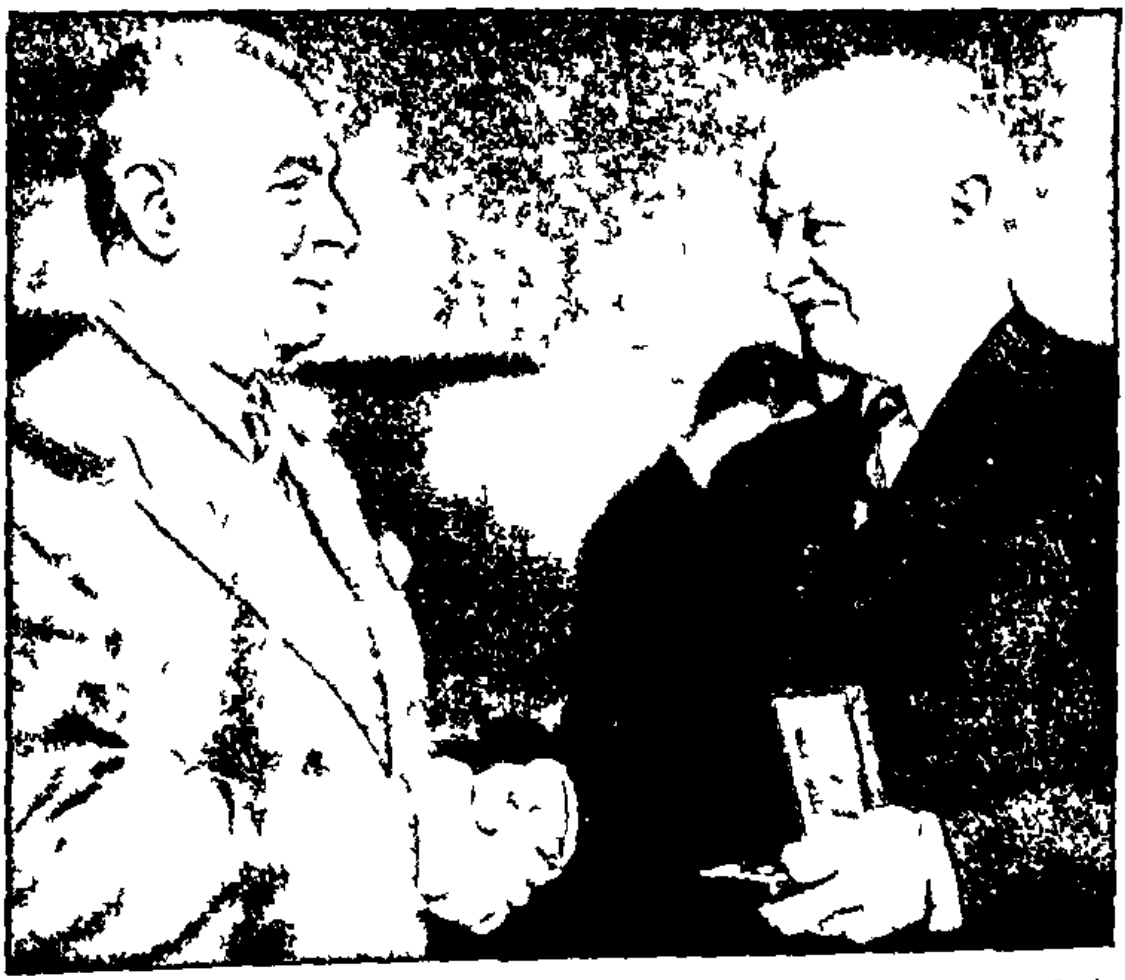
The various agencies operating in this area are now registering people and taking a census It has been arranged that as soon as there are medical officers in the camps these agencies will submit to the WHO representative a weekly report on births deaths and infectious diseases The agencies have also been requested to set up health clinics in the camps including facilities for dealing with maternal and child health and health problems of schoolchildren It is expected that, at the most, only one doctor will be available per 10 000 persons plans are therefore being made to recruit trained orderlies, or tamargis on as large a scale as possible

A committee has been set up under Dr Cottrell s chairmanship and comprising the chief medical officers of the three independent agencies which are charged with actual operations in the field the League of Red Cross Societies the International Committee of the Red Cross and the American Friends Service Committee This committee deals with matters of general medical policy and the distribution of medical supplies throughout the area It is the responsibility of WHO, through Dr Cottrell as its representative with UNRPR at Beirut to co-ordinate health programmes and to bring health services as far as possible under unified direction

Presentation of Egyptian Anti Cholera Medal to WHO

At the first meeting of the third session of the Executive Board held in Geneva on 21 February, Sir Aly Shousha Pasha on behalf of the Egyptian Government presented the Egyptian Anti Cholera Memorial Medal to WHO in recognition of the work accomplished during the recent epidemic [1]

FIG 6 EGYPTIAN ANTI CHOLERA MEMORIAL MEDAL — I



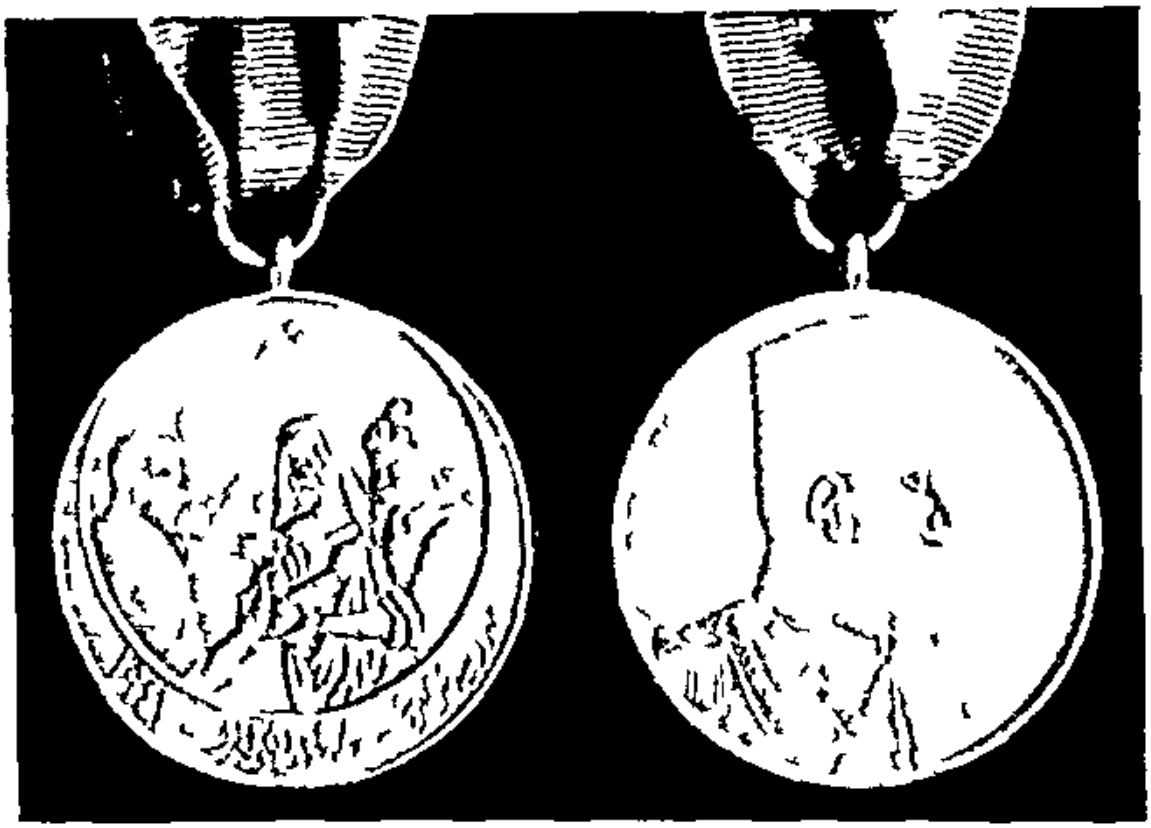
Dr Brock Chisholm Director General (right) receiving the medal from Sir Aly Shousha Pasha

Sir Aly Shousha Pasha recalled that, thanks to the collaboration of WHO and of the Egyptian Government human lives were saved suffering avoided and important sums economized In extending aid to Egypt WHO also helped other countries by taking measures for preventing the spread of the epidemic

[1] *Off Rec Wld Hlth Org* 1947 1 141 157

In the name of WHO Dr Brock Chisholm the Director-General, thanked His Majesty the King of Egypt, the Egyptian Government, and the Minister of Public Health for their expression of gratitude He pointed out that it was owing to the collaboration

FIG 7 EGYPTIAN ANTI CHOLERA MEMORIAL MEDAL — II



of all countries that were in a position to render assistance and to the energy of the Egyptian health authorities themselves that WHO was able to help Egypt in a concrete way in its struggle against cholera Results had shown what could be accomplished by a national public health service when it was well organized and seconded by international goodwill

International Survey on the Prevalence and Treatment of Trachoma

At its last session the Joint OIHP/WHO Study Group on Trachoma emphasized the fact that the data obtained by routine notification of cases in countries where the disease was widespread were too incomplete to be of real value and that far more reliable information could be obtained from special surveys made among schoolchildren, army recruits and other population groups The percentage of trachoma cases among patients in ophthalmic hospitals and clinics was considered also to be a good index of the prevalence of the disease

A circular letter was recently sent by WHO to governments, asking them to provide any recent information on trachoma prevalence as revealed by reports and studies made along the lines indicated by the study group Information was also requested on results achieved in the treatment of trachoma by the use of sulfonamides and antibiotics in view of the encouraging results recently obtained with some of these drugs in certain parts of the world

Seminar on World Health

A seminar on world health organized by the World Federation of United Nations Associations (WFUNA) will be held in Rome from 23 June to 3 July during the second World Health Assembly Approximately fifty students and young doctors selected by WFUNA are expected to participate A programme of lectures and speakers will be arranged by WHO Members of the seminar will attend some of the sessions of the Health Assembly

One of the main objects of this course will be to interest medical students in the work of WHO and to inform them on international medical activities particularly in the field of public health

Ecuador ratifies WHO Constitution

The Republic of Ecuador has just ratified the Constitution of WHO thus bringing the total number of Member States of the Organization to 59

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

THIRD SESSION OF THE EXECUTIVE BOARD

The third session of the Executive Board held in Geneva from 21 February to 9 March was devoted principally to the preparation of the programme of the Organization for 1950 and to the discussion of the budget required for carrying out such a programme The Board had the responsibility of commenting on the proposed programme and budget for the consideration of the Second World Health Assembly which will open in Rome on 13 June and at which the final decisions on the subjects examined by the Executive Board will be taken

It will be recalled that the general programme of WHO was laid down at the First Health Assembly and that during its first year the efforts of WHO were concentrated on the organization of control measures against malaria tuberculosis and venereal diseases on the improvement of maternal and child health and of environmental hygiene and on problems relating to nutrition It is not necessary here to mention in detail the various other activities of the Organization such as international epidemiology biological standardization the unification of pharmacopoeias etc all of which have been referred to in previous numbers of the *Chronicle*

International meetings of doctors and public health experts which have taken place since last summer in New Delhi [1] Paris [2] Geneva [3] and Cairo [4] have shown that many nations are faced with health problems which they cannot solve unaided The ravages wrought by tuberculosis malaria venereal diseases and parasitic diseases are apparent in many countries where the help of WHO is needed and there are in addition the general health problems of underdeveloped countries It was felt therefore that with the firm establishment of WHO the scope of its activities should be widened

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Note — The *Chronicle of the World Health Organization* is published monthly in English, French, Russian, Spanish and Chinese. The *Chronicle* reports the activities of the Organization without, however claiming to be an authoritative record of its official views, which are set out in the *Official Records of the World Health Organization*. All correspondence relating to it should be addressed to the World Health Organization, Palais des Nations, Geneva. Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom, more especially in the medical Press, are entirely at liberty to do so.

seafarers and to prevent the spread of venereal diseases in ports it is proposed that a research and demonstration programme of venereal-disease control methods be carried out in a large port Preparation for an international conference on serology to discuss the various methods used in the serological diagnosis of syphilis is also proposed

FIG 1 THIRD SESSION OF THE EXECUTIVE BOARD — I



From left to right S A ol L M d l ar D Mel ll M ckenzie Dr B Ko uszn k D H van Z le Hyde

WHO will continue to collaborate in tuberculosis control by sending demonstration teams organizing lecture tours and by maintaining technical assistance to the BCG vaccination campaign now in progress Research in connexion with the campaign will also be carried out under WHO auspices at the Copenhagen research centre [6] The scop. of the programme on maternal and child health and on environmental sanitation will be widened special attention being paid to nutritional and mental hygiene problems Plans have been made for sending teams to various industrial or university centres to collect information and undertake studies which will benefit other social groups at a later date

One item of the budget deals with a programme capable of producing far reaching effects the establishment of three health admini tration areas

See pag 77

Proposed Programme and Budget

The budget for 1949 of the Organization although totalling only $5,000,000, provides for a steady expansion, so that by the end of the year the programme will be operating at an annual rate of approximately $7,000 000 After consideration of the need for increasing the activities of WHO in the fields mentioned above, as well as of turning attention to new problems, the Executive Board decided to submit to the Health Assembly the budget proposals of the Director General for 1950 totalling $17,000 000 These proposals are published as No 18 of the *Official Records of the World Health Organization*, and are divided into two parts a regular budget of less than $8,000 000 to be financed through the contributions from Member States in accordance with the scale of assessments to be established by the Second World Health Assembly, and a supplemental operating programme of advisory and technical services costing a little more than $9 000 000 which would be financed by inviting governments in a position to do so, to indicate to the Second World Health Assembly their willingness to make additional contributions to WHO The latter programme is intended to cover new health projects and to extend the range of the existing programme In this way for example the sum allocated to malaria control would amount to more than $1,000,000 The final objective for the future must be the eradication of malaria by methods which have already produced such appreciable results in various countries [5] and demonstrations of such methods should be given in various parts of the world The increased budget would enable more demonstration teams to be sent to a greater number of areas Provision is also made for the organization of special training courses in malariology in areas especially in Central Africa and in South Eastern Asia, where such courses have not yet been instituted

Over and above this a new programme of malaria control is contemplated in collaboration with FAO with the double purpose of raising health standards of populations in agricultural areas and of increasing world food production By the simultaneous application of modern control methods and of improvement in agricultural production it would be possible to increase the agricultural productivity of large territories

An increased allocation is also proposed for the control of venereal diseases a subject with enormous possibilities for immediate action Model demonstrations with penicillin therapy are provided for so as to eradicate these diseases in highly endemic regions such as Bosnia Herzegovina (Yugoslavia) Such demonstrations would serve as a basis for later activities in Africa and Asia Information should be assembled for the revision of the Brussels Agreement so as to reduce the danger of infection for

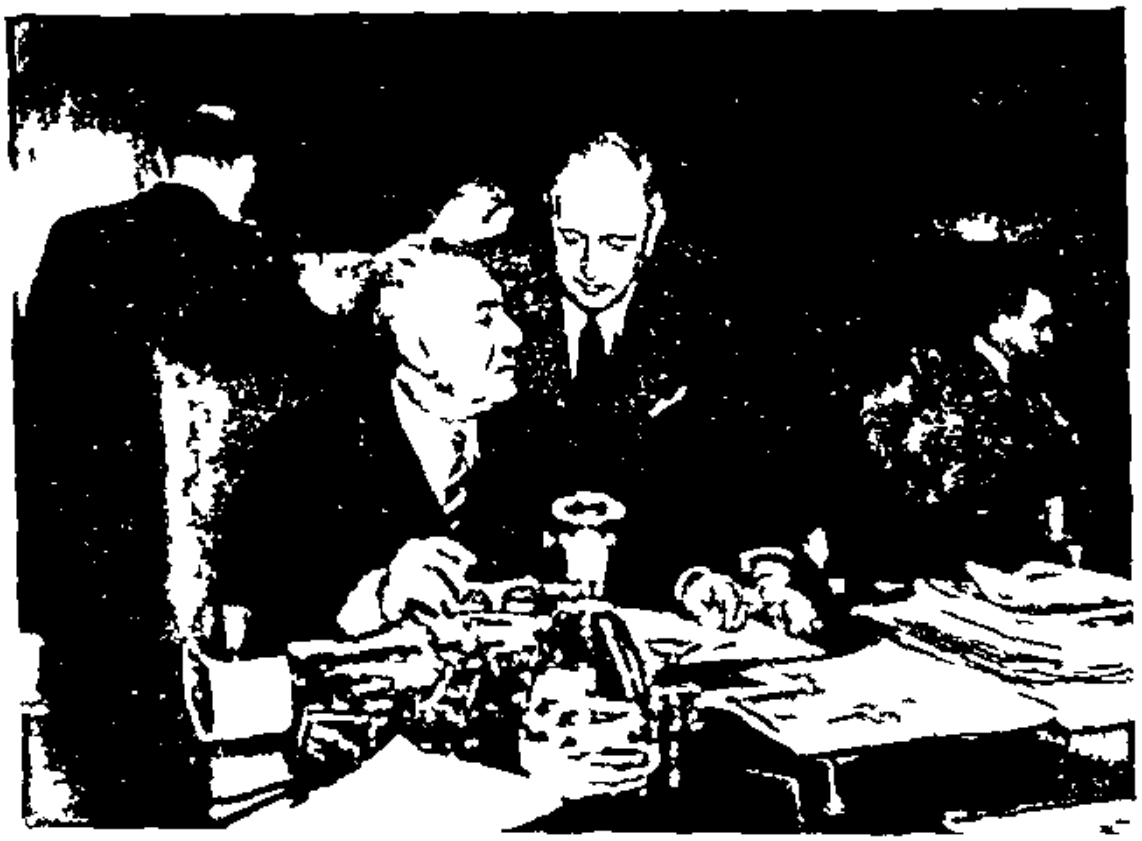
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Committee on Environmental Sanitation the Joint Committee on Nutrition, FAO/WHO and the joint committees with ILO on the hygiene of seafarers and on occupational hygiene meet in 1949

Co-ordination of Research Work

The Board noted the investigations carried out by the World Influenza Centre and congratulated the director on the work accomplished by the

FIG 2. THIRD SESSION OF THE EXECUTIVE BOARD — II



Left Si Aly Tewfik Shousha Pasha *Chairman* right Dr G H de Paul Souza

centre during the recent epidemic [11] Certain members of the Board pointed out that national health administrations would like to obtain more rapid and detailed information on the epidemiological development of the disease its clinical aspects and the morbidity and mortality rates

As regards research on brucellosis [12] the Board recommended that regional centres be designated in countries where the disease is prevalent and that brucellosis be added to the list of subjects for which co-ordinated research work under WHO auspices appears advisable The question of

[11] *Chron. World Hlth Org.* 1949 3 31
[12] *Chron. World Hlth Org.* 1948 2, 81

Such areas are to be chosen in territories belonging to WHO regional organizations which are confronted with at least one major health problem, and where the prevalent diseases can be controlled by modern measures At the same time a general public health programme will be put into operation One of the main purposes in this programme is to encourage national health administrations to apply modern prophylactic and control measures and to train local personnel

It is proposed to increase the sums allocated for fellowships by approximately $1,000,000 as this type of WHO activity has proved to be one of the most useful to governments It is believed that it will become even more important as health conditions in all countries improve

The project for the first international attempt to eradicate cholera and a budgetary allocation for this task were approved by the Executive Board Plans have been made for sending two teams to India and Pakistan to demonstrate methods of cholera control

The supplemental budget, moreover, provides for further activities such as typhus and plague control Measures will be undertaken against schistosomiasis, which has recently been shown to be prevalent in regions where its existence had not before been demonstrated and a team will be sent to one of the infested areas to carry out experimental measures in the destruction of molluscs the intermediate hosts of schistosomes, as well as other control methods

An item of the budget is devoted to assistance to governments in the technical training of medical and auxiliary personnel as well as in the health education of the public

Expert Committees

The Board examined and accepted the reports of the following expert committees, making observations and comments as the need arose international epidemiology and quarantine, first session (including the report of the quarantine section, first session) [8] habit forming drugs first session,[9] maternal and child health, first session [10]

The Board discussed the report on the third session of the Expert Committee on Tuberculosis which will consider the Board s observations at its next meeting when its membership will have been enlarged

The Board recommended that an Expert Committee on Plague and an Expert Committee on Antibiotics be established and that the Expert

[8] Chron World Hlth O g 1949 3 59
[9] Chron World Hlth O g 1949 3 1
[10] Chron World Hlth Org 1949 3 27
Chron World Hlth O g 1949 3 43

existing between ILO and WHO with regard to the health aspects of migration was stressed [15]

As a permanent council for the co-ordination of international congresses of medical sciences will be arranged in the near future as the result of joint UNESCO/WHO action [16] the Board recommended the adoption of certain propositions governing the collaboration of WHO

[15] *Chron. World Hlth Org.* 1949, 3, 55
Ch. W. Hl. Hlth Org. 1949, 3, 41

FURTHER RESEARCH ON TUBERCULOSIS

The antituberculosis vaccination programme which has been undertaken in Europe and Asia and which will later be extended to the Near East and North Africa offers a unique opportunity for collecting information on tuberculosis and on the results of BCG vaccination. As is now well known the organizations participating in this programme — the Danish Red Cross and its Scandinavian associates with material aid from the United Nations International Children's Emergency Fund (UNICEF) and technical help from WHO — are planning to test with tuberculin fifty million children and to vaccinate fifteen million in various European countries [1] Approximately eight million children have already been examined and three million vaccinated A tuberculosis research centre has just been established in Copenhagen in close association with this programme to which individual health cards and all relevant information collected during the vaccination campaign will be sent The Executive Board of WHO has allocated a sum of $100 000 to this centre which sum has been deducted from a grant allotted by UNRRA [2]

Dr C Palmer formerly Senior Surgeon of the US Public Health Service will assume the direction of this research centre He will have as collaborators Dr Lydia Edwards US Public Health Service and Dr I C Yuan formerly Deputy Minister of Health in China

Dr Palmer submitted to the Joint Committee on Health Policy UNICEF/WHO and to the WHO Executive Board a memorandum on the research work which should be undertaken both during field operations and at the research centre on the basis of the information collected Such work included the establishment of criteria for selecting persons for vaccination There are differing opinions with regard to the degree of tuberculin sensitivity required to differentiate those persons needing from those not needing

[1] *Chron. W. Hl. Hlth Org.* 1948, 2, 34
[2] *Chron. W. Hl. Hlth Org.* 1949, 3, 48

international research laboratories which had been submitted by the Economic and Social Council of the United Nations was also examined The Board was of the opinion that the best way of stimulating increased research on health was to assist, to co ordinate and to use fully the work of existing institutions The Health Assembly and the expert committees of WHO provided an adequate machinery for implementing this policy It was requested that the Economic and Social Council should communicate all recommendations on health to WHO

Regional Organizations

The Board noted that the Regional Office for South East Asia had begun operations on 1 January 1949 The choice of Alexandria as headquarters of the Regional Office for the Eastern Mediterranean which would begin to function on 1 July was approved subject to consultations with the United Nations Sir Aly Shoushra Pasha was appointed Regional Director for the Eastern Mediterranean

The Board approved the temporary arrangement reached with the Pan American Sanitary Bureau under which the Bureau pending its final integration with WHO [13] will act as the Regional Office for the Americas as from 1 March

The Board was of the opinion that a regional organization for Africa could not be established until the status of Member States in this region as well as the rights of application of Associate Members and other territories had been defined It is essential that such rights should be clearly defined by the Second World Health Assembly

Relations with Other Specialized Agencies and Organizations

The Board noted the progress report on the BCG research programme [11] which had been recommended by the Joint Committee on Health Policy UNICEF/WHO carried out in connexion with the anti tuberculosis vaccination campaign Dr C Palmer the director of the research centre will submit a report on his work to the BCG panel which will meet in April together with specialists appointed by UNICEF

The Board considered a proposal of the American Federation of Labor concerning the protection of the life and health of the worker in modern industry and decided that it should be submitted to the Joint Expert Committee on Occupational Hygiene, ILO/WHO The close collaboration

See page 92
See page 77

Philippines Poland Ukraine and Yugoslavia In addition to the programmes for fellowships visiting lecturers medical literature and special teaching material the Interim Commission of the World Health Organization continued at the request of the governments concerned advisory services established by UNRRA in the form of missions in China Ethiopia Greece Hungary Italy and Poland Accounts of their composition and activities have been published previously in the *Chronicle* [1] and have been kept up to date by information under the heading Notes from the Field

These missions have had three main tasks of which the third was the most important

(*a*) liaison between WHO Headquarters and the government concerned
(*b*) assistance to the government in the local administration of the programmes for fellowships visiting lecturers and medical literature
(*c*) advisory teaching and demonstration services upon request, in general public health administration and related fields such as nursing sanitation epidemiology distribution of medical supplies and the campaigns against malaria tuberculosis and plague

As the health services in these war-devastated countries became re established and health conditions improved some of these activities became redundant or no longer required the employment of imported staff Thus the liaison officer in Hungary was withdrawn at the end of 1947 and those in Poland and Austria in the autumn of 1948 In China conditions did not justify the replacement of staff as it became reduced by natural attrition In Greece the extent of aid given by the American Mission for Aid to Greece permitted the reduction of the WHO imported staff to two members whilst in Italy the staff would also probably have been withdrawn by now but for the development of a new and important project referred to below Only in Ethiopia in spite of many difficulties was it felt justified to continue the WHO mission at the same strength as at the beginning of 1947

The First World Health Assembly in July 1948 established the programmes and budget for 1949 it did not specifically authorize the continuation of missions in countries although it took note of the formal agreements establishing missions in Ethiopia Italy and Greece terminable at three months notice The Assembly approved the provision of advisory and demonstration services of consultants or teams to governments requesting them and established priorities for programmes in malaria tuberculosis venereal-disease control maternal and child health nutrition and environmental sanitation It also delegated to the Executive Board — which subsequently delegated to the Director General — the responsibility of making allocations to countries for the provision of these services

[1] *Chron. World Hlth Org.* 1947 1 73 173

vaccination The present lack of uniformity invalidates the reliability of statistical results, and only the use of uniform methods of vaccination and tuberculin testing would make it possible to estimate the role, among others of age country or nationality The sensitizing effect of various vaccines and the variations due to the methods of application would then have to be determined, and a study made of the effects of revaccination on allergy as well as on tuberculosis morbidity- and mortality rates, on all of which there is a lack of precise information at the present time

The material available to the research centre will enable it to carry out epidemiological studies which could not be undertaken previously In particular, it would be possible to compare the mean annual rates of infection for children between the ages of 6 and 14 in the different regions where the work is being carried out, according to observations made on the rate of conversion from negative to positive reactions to the tuberculin test

Strict scientific proof of the effectiveness of BCG vaccination is not available The opportunity afforded by the present programme should therefore be used to undertake studies, comprising the comparative observation of groups accepting and of others refusing vaccination Serious difficulties may arise in such studies, for, if they are to be of value it is essential, in particular, that vaccinated and non vaccinated persons should be observed over a long period, and that conditions permitting comparison between the two groups should remain throughout identical Without these conditions, the work will be useless

Other subjects of research are contemplated by the director of the centre in particular the possible influence of family, hereditary or radical factors on tuberculin sensitivity, the establishment of a uniform system of vital statistics permitting the evalution of changes in the tuberculosis mortality rate in various countries following BCG vaccination comparison of the results of tuberculin test and X ray examinations

NEW ORIENTATION IN FIELD ACTIVITIES

The end of 1948 closed, in some sense, a chapter in the story of the field activities of WHO under the 1949 programme changes have been necessitated in the policy and organization of such activities as well as in the type of assistance given to governments

During 1947 and 1948 the only funds available for assistance to governments in the field were those derived from UNRRA and were subject to the limitation that they were to be spent for the assistance of UNRRA aided countries only i e Albania Austria Byelorussia China Czechoslovakia Ethiopia Finland Greece Hungary Italy North and South Korea the

the WHO mission in charge as chief representative of WHO in the country concerned At present there are such offices in Shanghai Addis Ababa Rome (jointly with the Rockefeller Foundation for the public health administration survey) Beirut (for the refugee programme in the Palestine area) and Singapore (for epidemiological intelligence services only)

As and when regional offices are established these field offices — if still in existence — will come under the jurisdiction of the appropriate regional office

PUBLIC HEALTH IN TURKEY

Some Personal Observations

At the invitation of the Turkish Government Dr J M Vine Representative of WHO in Greece paid two visits to Ankara in May and October 1948 The object of these visits was to discuss with the Turkish Minister of Health and his chief officials various aspects of public health with particular emphasis on malaria, tuberculosis trachoma and the problem of a state nursing service The first visit lasted five days and the second five weeks during which Dr Vine made an extensive tour covering Ankara Istanbul and western and southern Turkey almost to the frontiers of Iran in the course of this he visited 146 institutions As a result of these visits plans were drawn up for future developments in tuberculosis and for the organization of a state nursing service Some of the observations made by Dr Vine during his visits are summarized below

There is in Ankara an efficient Ministry of Health with full services in all the provinces of this large country with its 20 000 000 inhabitants There is a corps of hygienists and sanitarians who are not underpaid and apply themselves to their work with keenness and energy This important point has been overlooked in many countries which therefore suffer from inefficiency in their government organizations

Recruitment to the civil service is assured by a system whereby a boy on leaving school can receive a government bursary which covers all further educational and living expenses until he graduates Then he must serve five years in state employment wherever the state sends him After that he may remain in the state service with two years seniority or he may leave for private work In practice the majority prefer to stay

The Turkish epidemiological service is good there is a separate division of malaria control directed from Ankara and covering over half the country The public health administration is well equipped with the usual other services and there is in addition a school of hygiene and a magnificent serum

An all important new factor which came into operation at the beginning of 1949 was that the funds from UNRRA had been expended or committed by the end of 1948, and consequently restriction of services to UNRRA aided countries lapsed Although the total amount available in the 1949 budget for field services was of the same order as in 1947 and 1948 — i e approximately $1,500,000 each year — the services now became available to some 55 nations instead of 15 the same amount of butter had therefore to be spread over much more bread

Of course many of the more highly developed countries have not requested services in 1949, and others from whom requests might have been expected to come have not yet formulated them But by the beginning of the year it was clear that the demands would be considerably in excess of the funds available to meet them In these circumstances it was clearly not justifiable to continue indefinitely even the much reduced missions in particular countries, and steps have been taken either to terminate them or to bring them into line with the other consultant and team services initiated or planned for 1949 These latter include among those already initiated (in some cases as joint projects with the United Nations International Children s Emergency Fund (UNICEF)) consultants or teams for malaria, in Afghanistan Albania, Bulgaria Hungary, India Iran Pakistan the Palestine area, Roumania Siam Turkey and Yugoslavia for venereal diseases in Afghanistan, Bulgaria, Czechoslovakia Denmark Finland Hungary India Italy Norway Philippines Poland Sweden and Yugoslavia, for tuberculosis in Egypt India and Latin America and for maternal and child health, in Ceylon Egypt and a group of countries in the Middle East

Special mention should be made of the project of the Italian Government whereby a joint survey will be made of the public health administration system, by consultants provided by the Italian Government WHO and the Rockefeller Foundation with the former chief of the WHO mission in Italy as executive secretary

Another field programme in operation since early January is the emergency health programme for aid to refugees in the Palestine area With the consent of the relief agencies operating in the area — the International Red Cross Committee the League of Red Cross Societies, the American Friends Service Committee and UNICEF — a medical officer with a small staff has been attached to the office of the Director of the United Nations Relief to Palestine Refugees (UNRPR) in Beirut and given responsibility for coordinating the public health and anti epidemic aspects of the relief work particularly in sanitation and malaria

Thus the advisory and demonstration services formerly provided by the WHO missions have been assimilated with the general field programmes Where justified by the number of staff or the duration of the programme in a particular country an office has been established with the former chief of

VENEREAL DISEASES IN ETHIOPIA

During the last two decades considerable progress has been made in tackling the health problems of Ethiopia Their importance has been recognized by the government, whose achievements in the short time since the war of liberation of 1941 1942 augur well for the future Much work however still remains to be done and competent outside assistance will be necessary for some years to come

Since 1909 when the Menelik Hospital in Addis Ababa was founded other hospitals have been opened by the Ethiopian Government, by foreign missions and by the Italians during the period of occupation but there are still only about 3 300 beds to serve 10-15 million people and elementary equipment is often lacking it is estimated that only about one tenth of the population has access to medical attention The two most serious difficulties encountered are lack of professional personnel and of funds Ethiopia possesses no practising physicians of her own and very few qualified nurses There are at present in the country some 70 foreign doctors and about the same number of nurses A committee on medical education recently estimated that about 5 000 technically trained workers including medical assistants nurses dressers and sanitary inspectors are still needed

Since the war of liberation several foreign medical groups have given assistance to the Ethiopian Government and more recently considerable help was received from the Health Division of UNRRA. The work begun by this organization was finally taken over at the beginning of 1947 by the WHO Mission to Ethiopia [1]

Work of the WHO Mission

The chief aims of this mission have been twofold first, to assist the government in planning and establishing a programme for the training of personnel and secondly to give technical and advisory assistance in certain problems The first of these aims was in conformity with the emphasis placed by the government on education in general The plan included three stages (*a*) elementary training in nursing and sanitation for dressers sanitary inspectors laboratory technicians pharmacy assistants and voluntary health workers (*b*) the establishment of a school for medical assistants with a three years course to be supplemented shortly by a school for nurses also with a three years course as well as plans for the advanced training of pharmacy assistants (*c*) possible university training Considerable progress has been made in the first two stages but the last has not yet

Chron. World Hlth Org 1947 1 179

laboratory and institute in Ankara There are medical schools both in Ankara and Istanbul The old, inefficient provincial institutions are steadily being replaced by modern hospitals in buildings excellent in design and equipment Health officers take pride in applying the principle of free treatment to all

The major public health problems in Turkey are those of tuberculosis, malaria, venereal diseases trachoma infant mortality and the lack of trained nurses Of these, tuberculosis is the most important but a comprehensive plan of control, trained staff, and funds are lacking Malaria is at present under control thanks to the use of modern methods Venereal diseases are steadily being reduced by organization and modern therapy Trachoma is heavily endemic in the southern provinces and is cared for by a special service of hospitals and dispensaries Sulfonamides of the type which were found so successful in Greece are now being used Few children were seen in the trachoma hospitals On infant mortality it is very difficult to give precise information, as such statistics as were seen gave no clear picture A special inquiry would be necessary to clear the situation some interesting graphs were seen, which indicate a close correlation between the decline in malaria and the rise in birth rate

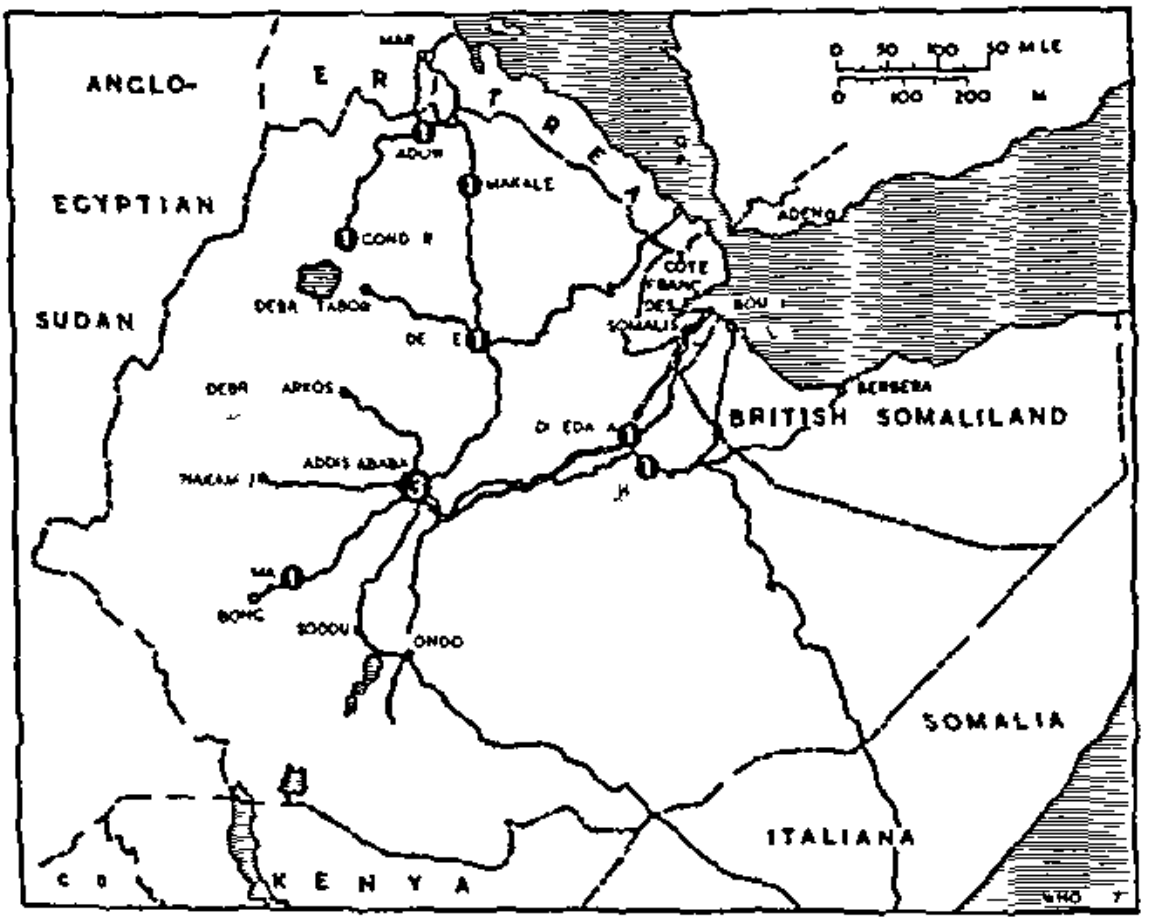
The death rate of 200 per 100 000 confirms the importance of tuberculosis The public health administration has less than 2 000 beds available and the dispensaries are not co ordinated with the hospital and sanatorium facilities Where sanatoria have been built they are entirely satisfactory in every way and there are a few dispensaries of modern type BCG is used only in a few centres in the large cities

During the last few months a national campaign was started and a real attempt to attack this problem was made Important sums have been allocated by the government and a five year plan is being evolved The people s interest is being aroused by propaganda of all kinds, and among all classes there is an awakening to the necessity of bringing tuberculosis under control

The nursing problem is acute for many reasons Turkey has emancipated its women, one of the results of which is that intelligent and educated girls can achieve careers in business with better material prospects than in nursing Furthermore, the only schools of nursing are situated in the two large cities of Ankara and Istanbul which also happen to be centres of commercial activities The quality of nurses is good especially those from the Red Crescent Training School in Istanbul However, at present Turkey has only 800 trained nurses of all types and on a basis of one trained nurse per thousand inhabitants there is a need for some 20,000 nurses This figure alone should suffice to show the magnitude of the problem which confronts the public health authorities in Turkey

Dr T Guthe Chief of the Section on Venereal Diseases of WHO visited Ethiopia from March to April 1948 to survey the situation A report of this survey has recently appeared in the *Bulletin of the World Health Organ i ation* [2]

FIG 4 MAP OF ETHIOPIA SHOWING POSITIONS OF PROPOSED VENEREAL DISEASE CLINICS



Extent of Syphilis

All types of venereal disease occur in Ethiopia but syphilis is the most frequently occurring of these and the most important from the social medi cal and epidemiological points of view It is however extremely difficult to assess the actual prevalence of this disease owing to the incompleteness of statistical data and to various other factors including limitations of technique false positive sero-reactions and little known racial and environ mental factors

The distribution of venereal diseases in Ethiopia as of other prevalent diseases is largely governed by climatic geographical sociological and

Bull World Hlth Org 1949 2, 85

FIG 3 WHO MISSION TO ETHIOPIA



Nurses and dressers trained under the programme established with the aid of WHO

been reached in the meantime qualified students are being sent to medical and other schools abroad some of them profiting from a limited number of fellowships provided by WHO

Among the problems in which WHO was to give technical and advisory assistance to the government nutrition tuberculosis and venereal diseases were chosen for detailed investigation

There are conflicting reports as to the prevalence of tuberculosis and venereal diseases but available information indicates that the latter and especially syphilis have constituted an important problem in East Africa for many years Special assistance from WHO in assessing this latter problem was requested by the Ethiopian Government and in response to this

A draft Venereal Disease Control Act was drawn up by various Ethiopian and other officials in consultation with Dr Guthe This covers the definition of venereal diseases treatment contact tracing statistical reports propaganda and health education in their legal and organizational aspects Detailed practical suggestions for the improvement of the various facilities are also given.

Finally it is estimated that five years would be required for the gradual extension of services under the draft Venereal Disease Control Act, and the estimated financial requirements for this proposed programme are given

TETANUS TOXIN AND ANTITOXIN

In a memorandum from the Department of Biological Standards National Institute for Medical Research London submitted to the Expert Committee on Biological Standardization and published in the *Bulletin of the World Health Organization*[1] an account is given of the present status of the problem of tetanus toxin and antitoxin There follow suggestions for research which should be undertaken in order to solve the various problems related to the assay of tetanus sera to the mode of action of toxin and to the properties of antitoxin

Research carried out by Llewellyn Smith has demonstrated that the comparative assay of samples of tetanus antitoxin is influenced by the toxin used the species of test animal and the route of injection Work undertaken by Petrie leads to the conclusion that crude tetanus toxins whether used as immunizing antigens or as test toxins are to be regarded as mixtures in varying proportions of the primary toxin molecule and of an antigenic variant of this Preparations of tetanus serum likewise consist of mixtures of the corresponding antitoxins Differences in mutual neutralizing affinities of these components in a reacting system account for the discrepancies in titre of tetanus sera when different test toxins are used for the assay Variations increase with the age of the culture from which the toxin comes

The varying composition of tetanus toxin and the multiplicity of antibodies in antitoxins make it possible to explain the difficulties encountered in standardizing tetanus antitoxin. However this theory does not explain why results obtained vary so much according to whether the assay of the titres is made on the mouse or on the guinea pig Petrie has put forward various hypotheses as an explanation of this phenomenon.

The discrepancy noted in titrations could also be explained by the unequal distribution of antibodies in the various fractions of the horse globulins

Bull World Hlth Org 1949 2, 59

economic factors The social and economic upheaval following the Italian occupation and the war of liberation, migratory movements, juvenile delinquency promiscuity, alcohol consumption, and, to some extent the codes governing marriage and divorce have all been contributory factors in increasing the incidence of venereal diseases Syphilis appears to be epidemic in the larger urban centres and endemic in both urban and rural areas Few systematic surveys have been made, but those carried out in 1944-45, by the US Technical Project in Ethiopia in three village areas (Ambo Gaunni and Shabe) deserve careful consideration

Diagnostic and Treatment Facilities

Except in Addis Ababa there are no special facilities for diagnosis and treatment of venereal diseases Patients suffering from these diseases are found in general wards with other patients, even in some of the main hospitals in the capital Most cases are, however, handled as outpatients at the Tekla Haimanot and Filwoha clinics The recently established Dedjajmach Balcha Hospital, which is staffed by Russian technical personnel has a special venereal disease department

There are few laboratories and the Kahn test is the only sero diagnostic test for syphilis carried out in Ethiopia Dark field examinations for *Treponema pallidum* are not usually performed

Ancient methods of treatment for syphilis and other venereal diseases are probably still practised in Ethiopia The general use of arsenicals introduced over the last decade and their conspicuous effect on dermotropic forms of syphilis has however, given the Ethiopians a certain amount of faith in modern medicine, and has given rise to the firm belief that intravenous injections are the only salutary procedure in many ailments

Many sulfonamides have also been used in gonorrhoea in recent years, but the variation in toxicity and treatment schedules with the different preparations has caused confusion in dosage, and it is probable that the creation of sulfa resistant gonococci has been furthered in this way

Penicillin has not been available in outlying clinics and dispensaries It has however, been distributed to hospitals for general purposes, and has thus been used in some cases of gonorrhoea, but no penicillin has been used for syphilis

Recommendations

The last part of Dr Guthe s report gives detailed recommendations for a venereal disease control programme The immediate necessity is an initial programme to meet present urgent needs, but this should come within the framework of a long term plan, and would provide the practical experience on which the latter could be developed

the Department of Biological Standardization State Serum Institute Copenhagen published in the *Bulletin of the World Health Organization*[2] The article gives a critical assessment of previous findings as well as some ideas on the present position with regard to the possibilities of standardizing the immunizing potency of toxoids

The first question discussed is the correlation between the immunizing dose and the response of the organism Two essentially different methods have been employed the first is the toxin method which consists in establishing a relation between the dose of toxoid and the percentage survival of guinea pigs to which doses of toxoid and toxin have been successively administered The second is the antitoxin titration method by intracutaneous injection in animals The authors discuss the theoretical bases of these two methods and illustrate their results by graphs The advantages to be derived from the second method are discussed at length If this is used for estimating the immunizing potency of toxoids it will obviously be necessary to rely on the method of evaluating cutaneous reactions following intracutaneous injections in rabbits as worked out by Jensen and Ipsen However this method has not proved entirely satisfactory in all cases In fact, it was noted that the results obtained varied considerably with the toxin concentration against which the serum was tested The authors examine the conditions under which these discrepancies are observed and raise the question as to what is biologically the correct antitoxin titre of a serum They propose the use of two different titres

In immunization experiments using potent APT preparations which it is necessary to dilute for injection it is important to ensure that this dilution does not change the preparation The advantages of certain solutions — sodium chloride being preferable to the phosphate buffer solution — and the principle which must govern the choice of the solution used as diluent are discussed in the last section of the article

Experimental data collected in the course of these experiments may perhaps enable the following fundamental problems to be solved Is it possible to compare directly the immunizing potencies of different toxoids? Or do toxoid preparations differ qualitatively to such an extent that a simple ratio between potencies cannot be established?

Research on diphtheria antitoxin suggests that at different stages of immunization different fractions of these globulins may carry antibody, such fractions would be expected to have quite different physical properties

Further studies should be devoted to many of these important points A wider range of research might be attempted with regard to toxin antitoxin and the test animal

Precise data on the local action of neurotoxin on neuromuscular transmission would be particularly useful, as it would be possible to contemplate new methods of assaying toxin and of estimating its activity Much recent work suggesting various solutions of this problem is summarized

A critical investigation of antibody bearing fractions of globulin in a number of sera might be attempted by electrophoretic and chemical methods correlating with the mouse/guinea pig ratio, the dissociability the speed of flocculation etc This last test could furnish data on the relative qualities of toxins and antitoxins

Research suggested for toxins and antitoxins, if applied to mice and guinea pigs, in parallel, might elucidate the differences between them

Finally principles are set forth in this memorandum, for the production of a stable toxoid with which an alum precipitated toxoid (APT) could be prepared

STANDARDIZATION OF DIPHTHERIA TOXOID

The crystallization of diphtheria and tetanus toxoids which has been accomplished during recent years has brought nearer to realization the establishment of highly purified standard toxoid preparations The Expert Committee on Biological Standardization recommended at its first session [1] that the samples of diphtheria toxoid offered by the National Institute of Health, Bethesda Md USA be distributed to various laboratories and that research be carried out with a view to the possible standardization of this substance

As no definite answer can as yet be given to the fundamental question of whether the measurement of diphtheria toxoids in terms of units is theoretically possible the evaluation of such toxoids in different countries will for the present depend on minimum requirement tests It would undoubtedly be a step forward if agreement could be reached concerning a uniform internationally accepted minimum requirement test

Various aspects of the problems arising in the standardization of diphtheria toxoid have been considered in a study by N K Jerne & O Maaloe of

[1] *Chron World Hlth O g* 1947 1 107

antivenene — i e $^4/_5$ of the certainly lethal dose (c l d) according to Banic & Ljubetic Following computation four distinct results are obtained for each serum on the basis of which a mean titre is also calculated

Tables accompanying Professor Grasset s article give detailed results of titration calculations for each serum according to both methods On the whole these results show only slight discrepancies When using the first method (titration at various levels) the discrepancy noted between extreme titres (maximum and minimum) obtained for a single serum varies between 0 and 10/0 for 7 of the 12 sera and reaches a maximum of 22% in the case of two sera When using the direct computation method at each level titration discrepancies vary between 0 and 21/ and are less than 5/0 for more than half the sera (7 out of 12)

A comparison of results obtained by the two methods of calculation shows that for a single serum there are slight variations from one mean titre to another the difference being less than 5% for 10 sera and reaching 12/0 for one serum only

The author believes that in the multiple level method titration at the lowest level (0 05 ml of serum) shows certain discrepancies probably due to the fact that the mixtures contain a dose of venom which is too weak

The quantity of venom contained in a mixture should not be less than 5 c l d according to Professor Grasset It would therefore be preferable to limit titration to the three levels of 0 3 0 2 and 0 1 ml of serum On the other hand the accuracy of titration seems to increase if the intervals between increasing doses of venom contained in the various serum venom mixtures are relatively small — 0 005 mg for example — and if each mix ture is injected into a sufficient number of mice

Of the three higher levels that of 0 2 ml seems to offer the most regular titrations A comparison of titres obtained by direct computation at this level (after the deduction of $^4/_5$ c l d) and mean titres obtained by the formula at various levels shows remarkable uniformity Differences be tween the two series of results oscillate between 0 15/ and 2 18/ for 9 out of 12 sera and between 4/0 and 6/ for two others in one case only does the difference amount to 11/ Titration at the level of 0 2 ml of serum seems to offer adequate guarantees of accuracy and regularity for deter mining the neutralizing power and mixtures produced at this level always contain a sufficient number of c l d of venom In addition a volume of 0 2 ml of serum allows for adequate doses of venom and the comple mentary saline solution which is required to bring the volume up to the 0 5 ml injected into each animal Moreover titration at a single level means a considerable saving both in standard venom used as antigen and in the number of animals required for titration operations

STANDARDIZATION OF COBRA ANTIBODY

The Permanent Commission on Biological Standardization of the League of Nations recommended that studies be undertaken with a view to the standardization of antivenenes As a result of research carried out at the South African Institute for Medical Research in Johannesburg, Professor E Grasset had shown [1] that it is possible to determine with sufficient accuracy the neutralizing power of African anti viper venom serum *(Bitis arietans) and anti-cobra venom serum (Naja flava), as well as the respective* cobra and viper antibodies contained in the polyvalent anti snake venom serum prepared at the institute, by using the method of titration at various levels of Banič & Ljubetič, as modified by Ipsen

Professor Grasset has recently published in the *Bulletin of the World Health Organization* [2] the results of his work at Johannesburg in which the same method was applied when assaying cobra antibody contained in concentrated therapeutic polyvalent sera destined for public use The accurate assay of this antibody appears to be particularly important as its neutralizing power is relatively speaking much less (in ratio of 1 10) than that of the antibody *Bitis arietans* and is capable of varying considerably according to the origin of the various sera

Research work, carried out according to the assay method used previously by the author,[3] related to a series of 12 polyvalent antivenenes having widely varying neutralizing powers, and obtained by two different methods 7 sera being concentrated by fractional precipitation and 5 sera purified by pepsin digestion and concentrated by ammonium sulphate Two concentrated venoms of different toxicity which had not varied over a period of four years, were used as antigens The various serum venom mixtures containing increasing doses of venom the difference between doses being 0 0025 mg to 0 01 mg for the same amount of each serum were injected into a number of mice which varied according to the sera from 2 to 8 Titration was carried out at four levels of serum 0 3, 0 2, 0 1 and 0 05 ml

The potency of each serum was calculated in two ways

(1) using the formula of Banič & Ljubetič as adapted by Ipsen in which the titres obtained at the different levels are introduced in pairs in all possible combinations, thus — titration having been carried out at four levels — giving six different results, and a mean titre is then calculated

(2) by direct calculation at each level after deducting the amount of venom which can be tolerated by the organism in the absence of a specific

[1] *Bull Hlth Org Lo N* 1941 9 476
Bull Wo H Hlth Org 1949 2, 69
[3] Described in detail in *Bull Hlth Org Lo N* 1941 9 476

enable Dr R Grubb of Lund and Dr P H Andresen of Copenhagen to visit the Lister Institute for the discussion of certain problems connected with the nomenclature of two blood group systems Lewis " and Lutheran "

It will be recalled that a new human blood group antigen which is believed to occur in 25 of the English population was discovered by Mourant in 1946 [3] This antigen was subsequently called anti Lewis The anti Lutheran agglutinin was discovered and described by Callendar Race & Paykoç in 1945 [4]

The discovery of these two previously unknown agglutinins is not only of theoretical interest for it has been shown recently in Australia by Jakobowicz, Simmons & Bryce that transfusion with Lewis incompatible blood may result in untoward incidents

Mono-specific Inaba and Ogawa Sera and Vaccines

Sir Sahib Singh Sokhey Director Haffkine Institute Bombay has informed the Secretariat that a preparation of the cholera mono-specific Inaba and Ogawa agglutinating sera recently produced at the King Institute Madras is now ready for distribution and collaborative assay

Monovalent dried culture vaccines of Inaba and Ogawa types supplied by Dr M V Veldee Chief Biologics Control Laboratory National Institutes of Health Bethesda Md have been forwarded to the State Serum Institute Copenhagen for distribution in view of assay Sir S Sokhey has provided the freeze-dried living strains to be held as reference preparations by the Kasauli Institute India for the comparison of the vaccines with their original strains

Cholera O Antigen

A reference preparation of cholera O antigen suitable for immunization of rabbits to produce antisera capable of distinguishing the true cholera and the El Tor strains from all other cholera like vibrios has been obtained by the late Dr P Bruce White of the National Institute for Medical Research London

Standardization of Anti A and Anti B Sera

Anti A and anti B blood group agglutinating sera have been distributed by the National Institute for Medical Research London to members of the Expert Committee on Biological Standardization interested in this problem The samples have already been tested by some of the experts and it is anticipated that an international standard will soon be adopted by WHO

Costa Rica and Honduras ratify WHO Constitution

Costa Rica and Honduras have ratified the Constitution of WHO thus bringing the total number of Member States of the Organization to 61

Mourant, A E (1946) *Nature Lond* 158 237
Callender, R R & Paykoç, Z V (1945) *Brit med J* 2, 83
Jakobowicz, R., Simmons, R T & Bryce, L M (1947) *Med J Aust* 2, 370

Notes and News

Extension of WHO Epidemiological Radio Broadcasts in French from Geneva

Since 25 March the French text of WHO radio epidemiological bulletins broadcast by long wave (4 800 metres) for the benefit of health administrations by station HBG at Genève Prangins have been transmitted also by short wave (44 97 metres) by station HBQ These two broadcasts which are beamed to Europe and North Africa take place every day at 9 20 (GMT)

It will be recalled that the daily broadcasting in English and in French of epidemiological bulletins began in January 1949 [1] This service which was begun on an experimental basis has been very favourably received and the health administrations of a score or more countries have already informed WHO of the value of such notifications Receiving stations ships at sea and private stations have supplied information on reception conditions

Port and national health authorities now receive information daily and will be in a position to carry out rapidly necessary measures against the introduction of pestilential diseases or to re introduce quarantine measures which have been allowed to lapse In approving the broadcasting service of epidemiological bulletins at its third session the Executive Board recognized its importance in the control of epidemics and requested that governments collaborate by re transmitting free the bulletins through radio stations which they own or control

Temporary Arrangement with the Pan American Sanitary Bureau

The Pan American Sanitary Bureau has been operating since 1 March as the WHO regional organization in the western hemisphere An arrangement to this effect has just been concluded pending the integration of the Pan American Sanitary Bureau with WHO which will take place when 14 of the member states of PASB have ratified the WHO Constitution [2] At present 13 of these countries have deposited their instruments of ratification

This temporary arrangement signed by Dr Brock Chisholm Director General of WHO and Dr Fred Soper Director of the Pan American Sanitary Bureau aims at bringing about uniformity in the programmes of the two organizations as soon as possible

Since its creation in 1902 the Pan American Sanitary Bureau has played an active part in co-ordinating measures for the improvement of health conditions in the various countries of the Americas and in preventing the spread of epidemics It is under its aegis that an antimalarial campaign is being carried out in several South American countries the final objective of which is the eradication from the American continent of vector mosquitos

Lewis and Lutheran Blood group Systems

In response to a request addressed to WHO by the British experts on the Rh factor Dr R R Race Dr A E Mourant and Dr W T J Morgan a grant has been made to

[1] *Chron World Hlth Org* 1949 3 35
[2] *Chron World Hlth Org* 1949 3 0

Views on WHO

Task of South Africa in the light of WHO Constitution

Addressing the Fifth International Congress of Pediatrics, New York, July 1947 [1] Dr Joseph Gilfman Medical School, University of the Witwatersrand Johannesburg said

" I appreciate very much indeed the sacrifice and personal effort made by individuals who have actively promoted this kind of international collaboration in matters which affect the welfare of the human race It is a practical step in the realisation of the objectives of the World Health Organization to which 61 nations gave their pledge on July 22nd 1946 This new health organization whatever its present limitations carries a message of hope to many people in different parts of the world At least those countries who have undertaken to support this international organization will remain interdicted as long as their people are denied elementary human rights in the form of security and health This applies particularly to countries inhabited by mixed populations.

The speaker then examined the tasks facing South Africa in fulfilment of her obligations towards her infants and children in terms of the new Health Charter "

India and WHO

An article has recently appeared in *People's Health* Madras (1948 3 57) in which an anonymous author described by the editor as a high authority " gives a history of WHO and explains the advantages which India may obtain from its participation in WHO

India's role it is stated is twofold firstly as a donor and secondly as a recipient Indian health services are still backward She has, however an ample amount of local talent in individual fields of medical endeavour This talent is being placed at the service of WHO through eminent Indian experts No less than five Expert Committees of the WHO contain Indian members who are taking a very active part in the formulation of WHO policy and programmes In the control of epidemic and endemic diseases India has a particularly important part to play on account of the extensive field experience gained in the country In the field of medical research too Indian scientists have played no mean part Even to-day Indian medical institutions are being utilised for the training of health personnel for other countries of Asia

As a recipient country India has, of course much to gain from her association with the WHO in the strengthening of her national health services by helping to train a vast army of doctors nurses and midwives health visitors and sanitary inspectors Fellowships for postgraduate studies in foreign countries are available from the WHO and eminent foreign experts in different medical specialities can be brought here if desired for demonstrating to the medical profession in India the modern advances in scientific knowledge A certain amount of medical equipment and literature is also available The main feature of WHO assistance however is the sending of demonstration and training teams to different countries These teams consist of experts who are posted to member countries for short periods in order to demonstrate disease control in selected areas and to train local personnel who will then take over the work and continue it under the national health authorities

" As the largest partner in the South East Asia region," concludes the author " India also has to lead the way in the energetic fulfilment of these international rights and obligations and so to strengthen further her ties with the WHO which is perhaps the only international organisation free from political considerations

[1] *Act paedi* 5 orkh 1948 36 83

Recent and Forthcoming Meetings

4 9 April	WHO/UNESCO Conference to establish the Council for Co ordination of International Congresses of Medical Sciences Brussels
12 13 April	Joint Committee on Health Policy UNICEF/WHO Geneva
20-30 April	Expert Committee on Unification of Pharmacopoeias Geneva
26 30 April	Sub-committee (of Expert Committee on Biological Standardization) on Fat Soluble Vitamins London
May tentatively first week	Preparatory Meeting of the Rhine River Commission on Venereal Diseases Geneva
2 7 May	Expert Committee on Biological Standardization London
10-14 May	Expert Committee on Insecticides Cagliari Sardinia
23 28 May	Expert Committee on Health Statistics Geneva
June	Joint Committee on Occupational Hygiene ILO/WHO Geneva
1-4 June	WHO/UNESCO Interim Co ordinating Committee on Medical and Biological Abstracting Paris
Before 13 June	Joint Committee on Hygiene of Seafarers ILO/WHO Geneva
13 June 2 July	Second World Health Assembly Rome
July first week	Executive Board fourth session Geneva
26 July 2 August	Expert Committee on Tuberculosis Copenhagen
10 17 August	Expert Committee on Malaria Geneva
September (probably)	Regional Committee for South East Asia New Delhi
September or October	Regional Committee for the Eastern Mediterranean Alexandria
October (tentative)	Joint Committee on Nutrition FAO/WHO Washington
October	Sub-committee (of Expert Committee on Venereal Infections) on Serological Standardization and Laboratory Aspects New York
Late October	*Expert Committee on Venereal Infections* New York
November	Joint OIHP/WHO Study Group on Cholera India
Autumn	Expert Committee on Mental Health Geneva
Autumn	Expert Committee on Plague Geneva
Autumn	*Expert Committee on International Epidemiology* and Quarantine Section on Quarantine and Yellow Fever Panel Geneva

PUBLICATIONS OF THE WORLD HEALTH ORGANIZATION *

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual English and French)

This publication intended for national health administrations and for health services at ports and frontiers contains notifications concerning diseases qualified as "pestilential" in the International Sanitary Conventions, as well as other information about the application of these Conventions

It is mainly intended for official use and is not for sale separately It can however be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below)

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(Bilingual English and French)

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The eighteen volumes of the Official Records so far published mark the successive stages in the evolution of WHO They comprise

No 1 Technical Preparatory Committee for the International Health Conference
—containing the minutes, with supporting documents, of the Paris meeting of March-April 1946, at which the form and scope of the future Organization were discussed and its Constitution tentatively drafted.

No International Health Conference
— proceedings of the Conference held in New York in June-July 1946, which culminated in the signing of the WHO Constitution The volume contains the text of the Constitution and other related A the summary report on the Conference, minutes of the plenary meetings, and supporting material

* All prices are post free

determined only to raise the standards of health of all peoples without distinction of race religion political belief economic or social conditions

International Medical Mission to the Philippines

An editorial in the issue for November 1948 of the *Journal of the Philippine Medical Association* (1948 **24** 663) comments on the visit of the small medical teaching mission sponsored jointly by WHO and the Unitarian Service Committee of America [1]

Heretofore Filipino physicians whether they be general practitioners or specialists have had to go abroad in order to come in contact with foreign specialists Unfortunately however not many of our physicians can avail themselves of the opportunities and advantages of travel Because of the great distance of the Philippines from the great medical centers of the world the cost of the trip to these centers in terms both of money and of time is prohibitive For this reason the coming of the International Medical Mission to the Philippines upon the invitation of our Government and under the joint auspices of the Unitarian Service Committee and of the World Health Organization should be of unusual import to the local medical profession

Pharmacopoeias

The seventh British Pharmacopoeia said Sir Percival Hartley in an address to the Pharmaceutical Society printed in abbreviated form in the *Pharmaceutical Journal* (1948 **161** 439) is more than a work of patient endeavour standing alone as it were in splendid isolation that description does not do full justice to the work as it fails to bring out the place it occupies in the integrated international achievements made in so many directions in the inter war period largely under the guidance and stimulation of the Health Organisation of the League of Nations with which the British Pharmacopoeia Commission developed and maintained close contacts and cordial co operation This work is being continued and developed by the World Health Organisation and the part which national pharmacopoeias are destined to play is very clearly set out in its Constitution its aims and its functions These are very specially directed to develop and establish and promote international standards with respect to the safety purity and potency of biological pharmaceutical and similar products moving in international commerce and the advertising and labelling of those products there is much concern too over dangerous drugs and drugs of addiction This brings the World Health Organisation with its manifold and benevolent activities its high purpose and its interests very near and gives an added significance and importance to our new Pharmacopoeia

Global Concept of Disease

In a paper presented at the Centennial Celebration of the American Association for the Advancement of Science summarized in a recent number of *Science* (1948 **108** 593) E C Faust dealt with the global concept of disease and concluded that disease was global in its extent and control measures must be conceived and carried out on a global scale This must be under the direction of a single co ordinating agency the World Health Organization

[1] *Chron. World Hlth Org.* 1948 **2** 63

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Complete analysis of the specific antigen of the cholera vibrio and its practical applications. J GALLUT

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Tetanus toxin and antitoxin. *Department of Biological Standards National Institute for Medical Research, London*

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FIRST ANNUAL REPORT OF DIRECTOR-GENERAL

THIRD SESSION OF JOINT COMMITTEE ON HEALTH POLICY UNICEF/WHO

CO-ORDINATION OF INTERNATIONAL CONGRESSES OF MEDICAL SCIENCES

VENEREAL DISEASE IN GERMANY

WORLD HEALTH ORGANIZATION

PALAIS DES NATIONS

GENEVA

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VOL. 3 No 5 MAY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

FIRST ANNUAL REPORT OF THE DIRECTOR-GENERAL

The *Annual Report of the Director General to the World Health Assembly and to the United Nations 1948* published in April 1949 [1] deals with the principal activities of WHO during the first four months of its existence from 1 September to 31 December 1948 The period covered by this first report has been essentially one of transition and intensive preparation, transition from the somewhat limited programme begun by the Interim Commission to the rather more extensive projects to be undertaken by WHO in 1949 and preparation for serious attempts in 1950 towards the realization of the ideals embodied in the WHO Constitution Yet despite the brevity of the period one is struck on reading this volume of 52 pages by the diversity of the programmes and by the amplitude of the tasks undertaken

Together with this increased activity the Organization itself has developed At the end of the year 56 States had accepted the Constitution of WHO Some progress had been made in regionalization the Regional Organization for South East Asia was established and the Regional Office set up in New Delhi on 1 January 1949 [2] the convening of the Regional Committee for the Eastern Mediterranean area was arranged for 7 February in Cairo [3] and a working arrangement with the Pan American Sanitary Bureau was being negotiated WHO also established a special administrative office for war-devastated countries in Europe to assist in the task of solving the problems of health and medical rehabilitation During the first four months of its existence WHO had in fact to establish its administrative organization, both at the headquarters in Geneva and in the regions as well as to direct measures towards the effective control of disease

Off Rec World Hlth Org 16
Chron. World Hl h Org 1948 2, 2_5
Chron. World Hl h Org 1949 3 13, 43

Practical Activities

By sending demonstration teams to the field by providing expert advice, by granting fellowships and by dispatching medical supplies and literature WHO has done its utmost to meet ever increasing demands from governments for health assistance In accordance with the policy outlined by the First World Health Assembly, these efforts have been devoted first and foremost, to the control of three of the principal scourges of humanity malaria tuberculosis, and venereal diseases The report of the Director General enumerates the activities of WHO in various countries and the results achieved up to the end of 1948 It emphasizes particularly the DDT spraying campaign in Greece,[4] the BCG mass vaccination carried out jointly with the United Nations International Children s Emergency Fund (UNICEF) and the Scandinavian Red Cross Societies [5] the founding of a laboratory for the manufacture of BCG vaccine in India [6] the penicillin therapy campaigns, carried out in co-operation with UNICEF in eleven European countries,[7] the extensive venereal disease control programme undertaken in Poland with government collaboration [8] and the fight against the epidemics prevalent among the Palestine refugees [9]

The aim of WHO being not only to fight disease but to ensure for every individual the highest possible standard of health the decisions of the First World Health Assembly and the work of the Organization have given high priority to questions of wide social significance, such as maternal and child health, nutrition and environmental sanitation To record only the most important activities of WHO in each of these spheres it is enough to mention the close co operation which has been ensured with UNICEF and other organizations devoted to maternal and child welfare collaboration with the Food and Agriculture Organization and the improvements in sanitation undertaken by WHO sanitary engineers in China, Ethiopia and Greece

Technical Services

Other health activities which are less spectacular because they do not involve field operations have been concerned with the establishment of international standards by expert committees of WHO Among the results already achieved the following can be mentioned the drawing up of international standards for certain chemical and biological substances used in medicine, the preparation of an international pharmacopoeia [10] and the publication of WHO Regulations No I regarding nomenclature with respect to diseases and causes of death [11]

Ch on World Hlth O g 1948 2 263
Ch on World Hlth Org 1948 — 34
Chron World Hlth Org 1948 2, 2 9 1949 3 4
Chron Wo ld Hlth Org 1948 2 67

[4] *Chron Wo ld Hlth Org* 1949 3 79
[5] *Chron World Hlth Org* 1949 3, 21 67
Chron World H lth Org 1948, 2, 243
Off Rec World Hlth Org 13, 349

Lastly by virtue of its statutory obligations WHO performed during 1948 certain epidemiological services such as the application of sanitary con

FIG 1 SOUTH EAST ASIA REGIONAL CONFERENCE



Pandit Jawah lal Neh u P ime Minister of India addressing the co ference

ventions concerning quarantine the preparation of new international sanitary regulations [12] the notification of pestilential diseases and the regular publication of epidemiological information

The report of the Director General thus shows how much of the extensive programme planned by WHO in accordance with the aims set forth in its Constitution, has either already been carried out or is under way In order that the task of WHO may be accomplished and disease fought everywhere effectively and continuously it is essential — as the Director General does not fail to emphasize at the conclusion of this first report — that the funds for the Organization should be regularly provided and that the delays apparent, during the first year in the payment of contributions by certain Member States should not create a precedent.

[12] *Chron World Hl h Org* 1949 3 1

THIRD SESSION OF JOINT COMMITTEE ON HEALTH POLICY, UNICEF/WHO

The Joint Committee on Health Policy, UNICEF/WHO, which comprises eight members appointed in equal numbers from the Executive Boards of the United Nations International Children's Emergency Fund (UNICEF) and WHO held its third session in Geneva on 12 and 13 April 1949[1].

This committee is only a temporary body established to control all the health programmes and projects of UNICEF until such activities have either been taken over by WHO or concluded. At this session the committee studied progress reports on programmes already under way, examined new programmes and considered questions of policy and procedure in connexion with co-operation between the two organizations.

The First World Health Assembly which met in June-July 1948 passed a resolution stating its belief that the health projects of UNICEF fell within the competence of WHO and declared that WHO was willing to handle these projects as soon as suitable arrangements could be made. The Health Assembly then recommended that pending the assumption of responsibility by WHO the health projects financed by UNICEF should be established by mutual agreement between UNICEF and WHO and that the implementation of these projects should be controlled by a committee on health policy composed of representatives of the two organizations acting with the advice of the expert committees of WHO.

The UNICEF Charter (paragraph 4 c) specifies that "to the maximum extent feasible the utilization of the staff and technical assistance of specialized agencies in particular the World Health Organization or its Interim Commission shall be requested with a view to reducing to a minimum the separate personnel requirements of the Fund".

Acting on the above recommendations the respective Executive Boards of UNICEF and WHO appointed members to the Joint Committee on Health Policy. Briefly the main function of this committee is to examine and approve all health programmes which are to be financed by UNICEF. When a medical programme has been approved in principle individual medical projects are submitted to the Director-General of WHO for approval before the programme is *finally authorized* by the Executive Board of UNICEF.

Progress Reports

At the third session, the committee studied progress reports on current health programmes, which dealt mainly with BCG vaccination, streptomycin distribution, antisyphilis campaigns and insect and malaria-control

[1] For list of participants see page 105.

campaigns and on demonstrations and training programmes arranged through groups and individual fellowships

FIG 2. JOINT COMMITTEE ON HEALTH POLICY UNICEF/WHO THIRD SESSION — I



Left to right (seated round table) Dr C van den Berg WHO Dr Brock Chisholm Director General WHO Dr B Babić UNICEF/WHO (Secretary) Dr M Mackenzie WHO (Chairman) Dr N M Goodman Secretariat, WHO Mr M Pate Executive Secretary UNICEF

BCG The report on the BCG vaccination programme was supplemented by an oral statement from by Dr H J Ustvedt Deputy Director for Europe of the Joint Enterprise [2] This organization was formed to establish liaison between UNICEF and the Scandinavian Red Cross Societies in order that the BCG vaccination work already begun by these voluntary organizations in a number of countries in Europe might be carried forward The three voluntary societies concerned are the Danish Red Cross the Norwegian Help for Europe and the Swedish Red Cross

Vaccination campaigns are proceeding rapidly in Europe it is expected that those in Czechoslovakia Finland and Poland will be finished before the end of 1949 Campaigns have been started in Austria India Lebanon and Morocco [3] and applications for supplies of BCG vaccine have been received from the governments of Bolivia Ecuador Iran and Israel Surveys are in progress in certain Latin American countries

Chron. World Hlth Org 1948 2, 34
Chron World Hlth Org 1949 3 7

Streptomycin The stringent conditions under which streptomycin is supplied are to be reviewed by the WHO Sub Committee on Streptomycin

Antisyphilis campaigns Reports were submitted on the progress of the antisyphilis campaigns which were begun in 1949 in Bulgaria Finland, Hungary and Yugoslavia and in 1948 in Poland [4] WHO experts in venereal diseases have recently visited these countries, giving lectures and practical demonstrations on penicillin therapy and laboratory procedures Other experts have carried out surveys in Italy and Slovakia and consultations will take place in the near future with the health authorities in Albania Greece and Roumania with a view to developing anti venereal disease programmes in these countries WHO has assisted UNICEF by making recommendations on the quality of penicillin and the procurement of laboratory equipment

UNICEF programmes in the Far East A special report was submitted by Dr M H Watt, chief of the UNICEF Mission to the Far East, on the progress of health programmes in that area He said that at present the two main health problems were malaria and tuberculosis and that the need for nutrition programmes seemed to be diminishing Proposals would be accepted for the establishment of training centres and also for anti venereal disease and yaws-control campaigns Great interest was being shown in the UNICEF fellowship programme which is being administered by WHO

Reports were also submitted on the group training programmes in paediatrics and on the insect and malaria-control projects

Programmes Considered

The committee approved in principle a number of new programmes including the provision of equipment for the diagnosis of tuberculosis and an extensive programme in maternal and child health which involves the provision of school health services maternal and child health centres child guidance clinics dental health services, maternity and children s hospitals, the care of handicapped children the treatment of skin diseases of children and the training of doctors nurses and auxiliary medical personnel in maternal and child care Requests from governments for such assistance will be acted upon by UNICEF provided that the plans of operations are approved technically, by the Director General of WHO

The committee agreed that programmes for the BCG research work at Copenhagen [5] for relief to Palestine refugees [6] for paediatric fellowships and for work in connexion with the rehabilitation of the UNRRA penicillin plants should be financed from the special fund of $1,000 000 [7] granted

[4] *Ch on. Wo ld Hlth Org* 1949 3 9
[5] *Ch on World Hlth Org* 1949 3 77
[6] *Ch on World Hlth O g* 1949 3 67
[7] *Chron World Hlth Org* 1949 3 45

to WHO by UNRRA for use on programmes approved by the joint committee Programmes for a joint study with the UN Statistical Office on the wastage of human life in relation to women and children and for an increase of WHO headquarters staff in the Maternal and Child Health Section were also accepted [8]

FIG 3 JOINT COMMITTEE ON HEALTH POLICY UNICEF/WHO THIRD SESSION — II



Left to right (ted rou d tabl) Mr M Pate Exe uti Sec tary UNICEF M A E Da ldson, S cret I t, UNICEF D L R Ichma Chairman E ecut Boa d UNICEF

Other projects approved by the committee include a Yugoslav programme for a campaign against fungus diseases and a scheme for sending additional funds to Arab refugees for use in sanitation water supplies and fly and malaria control An extensive health programme for China in child welfare tuberculosis and kala azar was approved subject to further discussions with the Chinese Government and to the technical approval of WHO

It was agreed that further discussions were required on the child health programmes for Latin American countries

A request for UNICEF to finance a scheme which would enable doctors to attend the International Congress on Paediatrics in July 1950 was referred for further study [9]

Views were exchanged on the proposal of the French Government

FIG 4 JOINT COMMITTEE ON HEALTH POLICY UNICEF/WHO THIRD SESSION — III



Left to right D W M Bo ne Secretari t, WHO Dr M Junod Chi a M ission UNICEF Dr P Z King Secr tariat, UNICEF

Chron. World Hlt h Org 1949 3, 43
Off Rec World Hlth Org 19 41

to establish an international children s centre in Paris, this discussion however, was informal as the subject was not on the agenda before the committee

Co-operative Policies and Procedures

The committee considered various proposals for obtaining closer co operation between UNICEF and WHO in their health programmes The following recommendations on policy and procedure were adopted

For the purpose of carrying out the intent of paragraph 4 (c) of the Charter of UNICEF [10] the following principles will immediately govern the co operative relation ship between WHO as the UN specialized agency recognized as the directing and co ordinating authority on international health work and UNICEF with regard both to health programmes approved by the Joint Committee on Health Policy and any new health programmes which may be developed for its consideration

(*a*) When international health experts are required for assisting governments in drawing up plans of operation for UNICEF health programmes it will be the responsibility of WHO to make available to governments such experts upon the invitation of the countries concerned

(*b*) The Director General of WHO will study and approve plans of operations for all health programmes which fall within the policies laid down by the Joint Com mittee on Health Policy and for which countries may request supplies from UNICEF

(*c*) All international expert health personnel agreed with governments as necessary for the implementation of any health programme will be made available by WHO

(*d*) UNICEF s role in health programmes is in accordance with its charter to furnish under its agreements with governments the required supplies and services and through its staff to observe that the principles of the Executive Board are main tained in their utilization

(*e*) WHO s role in carrying out the foregoing arrangements is subject to the provi sions of its Constitution and the limitations of its resources but beyond this will provide the services which will be reimbursed by UNICEF

(*f*) UNICEF will inform governments of the foregoing arrangements

In addition, procedures on the timing of the submission to the various bodies concerned viz the Joint Committee on Health Policy and the Programme Committee and Executive Board of UNICEF were worked out, and it was made clear that no utilization of funds would be approved until a plan had been submitted by the country concerned to UNICEF and approved by the Director General of WHO

Finally, the committee recommended that the Executive Director of UNICEF and the Director General of WHO should consider the value of joint UNICEF/WHO missions in areas in which health programmes consti tuted the predominant UNICEF activity

[1] See page 100

LIST OF PARTICIPANTS

Members

UNICEF

Dr L. Bugnard Directeur Institut national d'Hygiène Paris France
Dr A R. Lindt, Swiss Legation London United Kingdom
Dr L. Rajchman Chairman, Executive Board, UNICEF New York, USA
Dr B Schober Ministry of Health Prague Czechoslovakia

WHO

Dr C. van den Berg, Director-General for International Health Affairs Ministry of Social Affairs, The Hague Holland
Dr H van Zile Hyde Medical Director US Public Health Service Washington, D C USA
Dr M Mackenzie Principal Medical Officer Ministry of Health, London, United Kingdom *(Chairman)*
Dr A. Stampar President, Yugoslav Academy of Sciences and Arts Professor of Public Health and Social Medicine University of Zagreb Yugoslavia

Secretary

Dr B Borčić, Liaison Officer WHO

Also present

Dr H J Ustvedt, Deputy Director for Europe Joint Enterprise

Secretariat

UNICEF	WHO
Mr A E. Davidson	Dr Brock Chisholm, Director General
Dr P Z. King	Dr N M Goodman Acting Assistant Director-General
Mr M Pate	
Dr M H Watt	

CO-ORDINATION OF INTERNATIONAL CONGRESSES OF MEDICAL SCIENCES

A new international non governmental body, the main object of which is to co ordinate international congresses of medical sciences was created at Brussels in April 1949 The final establishment of this new organization was the result of much preparatory work carried out by a group of scientists, under the joint sponsorship of WHO and UNESCO,[1] and of a Constituent Assembly which met from 4 to 8 April 1949

Need for a New Organization

The need has long been recognized for a permanent organization to ensure continuity and co ordination of medical congresses nothing existed corresponding to the International Council of Scientific Unions, which co ordinates the activities of most of the international organizations in pure science Whilst it was fully realized that new international organizations must not be permitted to appear indiscriminately in large numbers it was also obvious that the lack of a central co ordinating body for medical congresses often resulted in confusion, inefficiency and loss of money This shortcoming became even more acutely manifest after the second World War when many international organizations, which had been inactive for almost ten years, resumed their normal activity

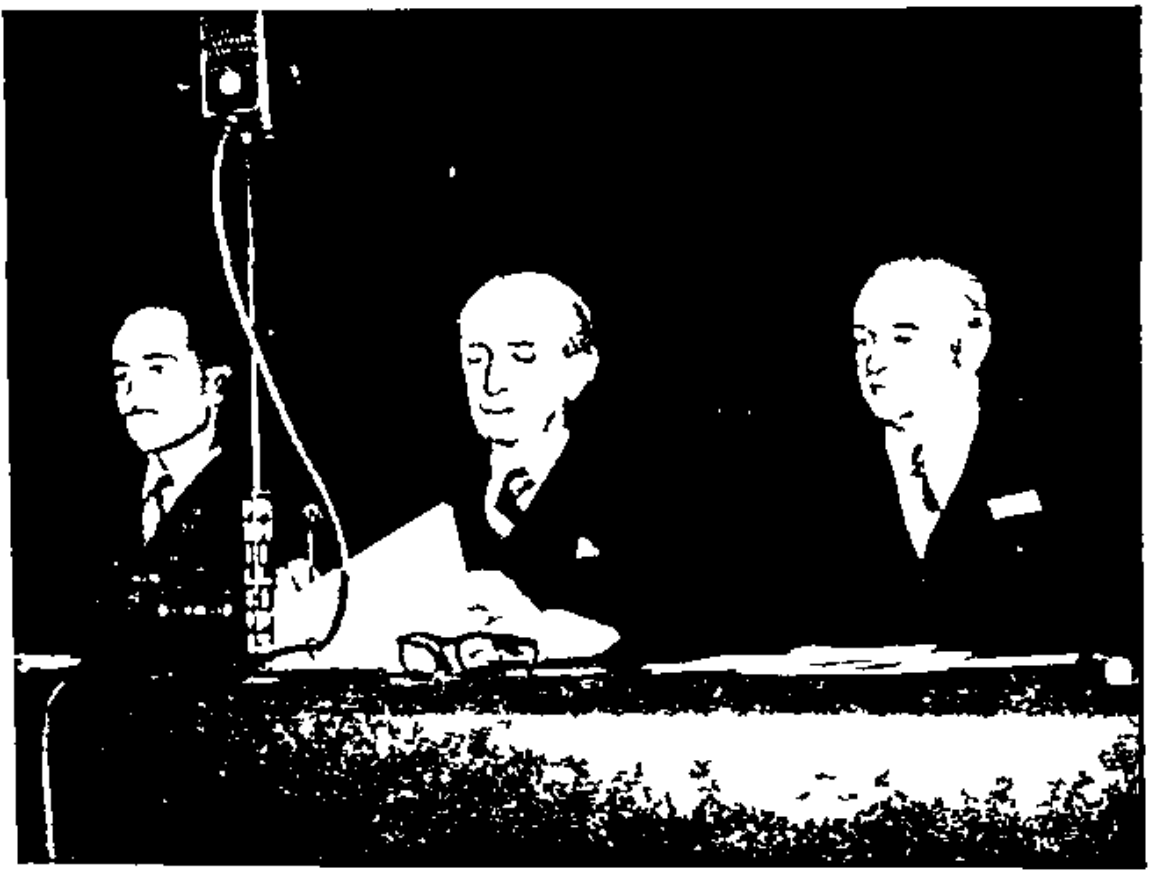
As pointed out by an observer at the Constituent Assembly at Brussels [2] " In the present complex state of scientific development, the classical system of holding medical congresses appears obsolete For instance, a congress on a particular subject may be of interest to specialists in related subjects who are often prevented from attending by the fact that meetings of their own specialities are taking place at the same time The expense and time involved are also frequent factors in preventing the attendance of medical men at congresses

Other examples could be given of the shortcomings in the former system of organization of medical congresses Most medical congresses have been organized in spite of grave administrative and financial deficiencies General conference services such as interpretation translation and publication of proceedings, may not be among the problems recognized by every participant, yet anyone even remotely connected with organizational problems must be alive to the fact that the ultimate success of a congress depends upon such matters of detail Here again much may be expected from a central organizing bureau If the new body succeeds

[1] *Chron World Hlth Org* 1948 2 38 63 1949 3 40
[2] Handler J (1949) *UNESCO Courrier* 2, 11

— as is hoped — in granting subsidies to medical men wishing to attend congresses but unable to do so at their own expense it will be readily understood that the Council for Co-ordination of International Congresses of Medical Sciences ought not to be sceptically received as just another international organization

FIG 5 COUNCIL FOR THE CO ORDINATION OF INTERNATIONAL CONGRESSES OF MEDICAL SCIENCES



Opening meeting of the Co stitue t Assembly Bru sels 4 April 1949 Left to right Baron F X van der St te Wallet, Mini t e de la Santé p bl q e (Belgi m) M C H ysma s Mi stre de l Ins truction p bliq (Belgium) Dr Brock Chisholm (Directo Ge eral WHO)

Meeting of the Constituent Assembly

The opening meeting of the Constituent Assembly was held on 4 April with M C Huysmans the Belgian Minister of Education as chairman Delegates of 38 international organizations and a number of observers took part in the meeting together with numerous Belgian personalities [3] At this meeting Professor J Maisin who had been chairman of the executive committee entrusted with preparatory work, read his report and thus provided the Constituent Assembly with a basis for discussion. Professor R Debré was elected Chairman of the Conference and Professor J Maisin

[3] A list f the organizations represented and their deleg tes ppears on page 109

and Dr R Paterson Vice Chairmen Dr K Soddy became Honorary Secretary

The statutes of the organization as proposed by the executive committee were accepted with some amendments and signed by the delegates of 38 organizations Signatures were, however subject to ratification by congresses or general conferences of each organization

Composition and Objects of the Council

The work of the Council will be carried out by a General Assembly and by an Executive Committee

The General Assembly, which is the supreme authority of the Council is composed of representatives of member organizations, the Assembly meets regularly once every three years, but special sessions may be convened at any time by the Executive Committee acting on its own initiative, or at the request of a majority of members of the Council

The main functions of the Assembly are to determine the policy of the Council, to elect the members of the Executive Committee to consider and approve the reports of the Executive Committee to decide the scale of contributions of members to supervise the financial policy of the Council and to review and approve the budget

The Executive Committee is composed of nine members, designated by organizations elected for that purpose by the General Assembly for periods of three years The Executive Committee will carry out the routine work according to the instructions of the General Assembly

The objects of the Council as outlined by the statutes are the following [4]

Information and Co ordination

(*a*) to collect information on all international and national medical or related organizations as well as on congresses organized by them with particular reference to the present and future programmes of these congresses their dates the subjects studied, and the names of the rapporteurs

(*b*) to suggest to international medical organizations suitable dates and plans for their congresses with special attention to the question of the grouping of subjects

(*c*) to study techniques of congresses and to provide information on this subject.

Assistance

(*d*) to provide material assistance for special congress services and to facilitate the travel arrangements of those attending

(*e*) to investigate the means of facilitating the transfer of necessary funds for members of congresses

(*f*) to give financial aid for the scientific work of congresses and to make grants to enable members to attend whose presence at the congress seems particularly desirable

(*g*) to make grants to enable representatives of different specialities to take part in congresses

[4] The following extract is an unofficial translation from the French

Distribution of Information

(*h*) to distribute information received from the various medical and related organizations

(*i*) to assist in the distribution of reports of congresses

(*j*) to study the question of medical information in connexion with congresses and to encourage its distribution

Item (*c*) deserves special mention Recent experience has shown that new techniques in the organization of scientific congresses might be studied and eventually tried out with great advantage The first International Congress on Mental Health which took place in London in August 1948 [5] offers a good example The congress was preceded by a vast amount of preparatory work More than 300 study groups worked in 27 countries in some cases for more than a year studying from every possible angle the problems which were expected to be debated at the congress itself It was largely due to this fresh approach that participants in the congress succeeded in completing their work in a relatively short time and without unnecessary expense These and other innovations might be adopted with advantage by other organizations and it will be one of the main tasks of the Council to study and improve them

A proposal that international postgraduate courses should be organized in connexion with congresses was warmly received and a resolution recommending the development of the project and its support by the Council was passed unanimously

It was decided that the official seat of the Council would be in the country of residence of the first Chairman of the Executive Committee As Professor Maisin was elected Chairman of the Executive Committee Belgium has become the official seat of the Council It was further agreed that the Secretariat of the Council would remain in Paris at UNESCO House and that WHO would be adequately represented in the activities of the Council

ORGANIZATIONS REPRESENTED AT THE CONSTITUENT ASSEMBLY AND THEIR DELEGATES

[The titles given are unofficial translations from the French.]

Fourth International Congress of Neurology	Dr A Tournay
Fourth International Congress of Otolaryngology	Dr F C W Capps
International Academy of Forensic Medicine and of Social Medicine	Professor M de Laet
International Association for Gastro-enterologic Research	Dr G Brohee

[5] *Chron World Hlth Org* 1948 2, 220

International Association of Allergists	Professor A Grumbach
International Association of Clinical Biology	Dr S C Dyke
International College of Surgeons	Dr W Carpenter MacCarty Sr
International Committee of Military Medicine and Pharmacy	Médecin-Colonel H Gloneux
International Committee on Cardiology	Dr F R Van Dooren
International Congress and Fourth American Congress of Gynaecology and Obstetrics	Professor J Snoeck
International Congress on BCG	*Professor C. Guérin*
International Council of Nurses	Mlle M Bihet
International Council of Ophthalmology	Professor E. Velter
International Dental Organization	Dr M F Watry
International Federation for Medicine and Physical Culture	Professor A Govaerts
International Institute of Embryology	Dr A Fisk
International Leprosy Association	Dr R Chaussinand
International Paediatric Association and Congresses	Dr R Debré
International Society for Blood Transfusion	Professor A Tzanck
International Society of Criminology	Dr Y Porcher
International Society of Haematology	Professor P Lambin
International Society of Internal Medicine	*Professor A Gigon*
International Society of Orthopaedic Surgery and Traumatology	Dr J Delchef
International Society of Surgery	Dr L. Déjardin
International Society of the History of Medicine	Dr F Sondervorst
International Union against Cancer	*Professor J Maisin*
International Union against Tuberculosis	Dr G Derscheid
International Union against Venereal Disease	Dr L. Dekeyser
International Union of Nutritional Sciences	Professor E. J Bigwood
International Urological Society	Dr P Bouteau
Medical Women s International Association	Dr M Straus
Permanent International Committee of Congresses of Comparative Pathology	Dr L. Grollet
Permanent International Committee on Industrial Medicine	Professor L. Carozzi
International Congress of Psychiatry	Dr H Ey
Second International *Congress of Electroence* phalography	Dr H Gastaut
Sixth International Congress of Radiology	Dr R Paterson
World Federation for Mental Health	Dr K Soddy
World Medical Association	Dr P Cibrie

VENEREAL DISEASE IN GERMANY

The control of venereal diseases in Germany was one of the most arduous tasks which faced the Occupation Authorities after the second World War In an article which appeared in a recent number of the *Epidemiological and Vital Statistics Report*[1] Dr T Guthe Chief of the Venereal Disease Section of WHO surveyed the situation in Germany from 1945 to 1948 and gave a detailed account of the result of measures taken in the various zones during that period

At the time of the surrender of the Third Reich most of the laws in force relating to venereal diseases were those enacted by the Weimar Republic These laws stipulated that contagious cases must be isolated that persons with venereal diseases must submit to treatment and must not marry such persons were in addition barred from certain occupations The Weimar Republic had outlawed prostitution, whether organized or clandestine The Nazi regime considered however that such drastic measures would contribute to immoral behaviour and again made houses of prostitution legal in all cities with a population over 15 000 Medical examination of prostitutes was re introduced Furthermore the Reich Law of 1935 on the protection of racial health required a pre marital health certificate which implied without expressly prescribing a pre marital serological examination.

Occupation Authorities and Problem of Venereal Diseases

Immediately after the surrender a number of temporary measures were introduced by the military occupation authorities in the various zones Uniform procedures were established in the three western zones and measures co-ordinated by the Allied Kommandatura were introduced in the four sectors of Berlin Emphasis was placed on case finding, available free treatment, reporting and follow up of contacts

To attempt to suppress prostitution in Germany was a tremendous task for both the civilian and military authorities all the more so as pros titution was in many cases the only possible means of subsistence for women and their dependent families

Since 3 October 1945 the United States Military Government in Ger many has required all persons arrested for prostitution vagrancy pimping and curfew violation, to be examined for venereal diseases It was found that 30% to 50% of arrested persons have positive reactions The follow up of contacts at first confined to soldiers and later extended to civilians

[1] *Epidem vital Stat Rep* 1949 2, 2

has proved to be a valuable part of the case finding programme The very active contact tracing work carried out in Berlin — where 65% to 80% of the contacts reported are actually examined — has contributed considerably to the decline in the incidence of syphilis

Venereal diseases were not included in the notifiable group of communicable diseases in Germany, so that the available data on this subject are not complete The German health authorities made several nation wide venereal disease surveys between the two wars the results of which showed an overall downward trend 215 000 cases of syphilis were recorded in 1919 and only 34 000 in 1940 syphilis representing 18% of all venereal diseases in 1927, and 20% in 1940

The venereal disease problem in Germany is not due to the presence of occupying troops and displaced persons although this view is often expressed by Germans Venereal diseases increased steadily in Germany as in other countries, as a consequence of war conditions displacement of civilian industrial and military populations social economic and political upheavals disruption of family life increase of promiscuity and prostitution Surveys carried out at Frankfurt on Main and Hamburg show that venereal diseases caused considerable ravages among the civilian population during the second World War

The increase in venereal infections which took place during the war in civilian and military populations in the Reich was also observed in several countries occupied by or allied with Germany as recorded in Denmark Finland, France, Greece, Norway and some of the Balkan countries

Position in the Various Zones

United States Zone A gradual rise in the incidence of venereal diseases was observed from June to December 1945, and a marked increase in gonorrhoea in the summer of 1946 — when a maximum of 90 per 10 000 population was recorded — followed by a marked decline This applies to all parts of the US Zone except Bremen where a rise in gonorrhoea was observed at the beginning of 1947, probably owing to the special conditions in this port where many troops are embarked and disembarked

Serological tests for the diagnosis of syphilis are carried out in the larger isolation hospitals and in the laboratories of the more important health departments Flocculation tests are usually employed as difficulty in maintaining laboratory animals limits the use of complement fixation tests

Treatment and supervision of patients were centralized in a limited number of venereal disease centres In August 1945 57 venereal disease isolation hospitals with a total bed-capacity of more than 5 000 were in operation, in 1947 there were 113 hospitals with a total capacity of 10 000 beds Treatment for syphilis was carried out until 1948 by the usual

European method of intermittent courses — an arsenical plus bismuth or mercury — with rest periods between courses In 1945 it appeared that 50/ to 70/ of patients suffering from gonorrhoea were resistant to sulphon amide treatment Penicillin was therefore made available in October 1945 by the US War Department for antigonococcic treatment in the civilian population, specific instructions being given for its administration

The availability of penicillin for this treatment throughout the US Zone must be considered an important factor in the decreased incidence of gonorrhoea as more than 210 000 patients were treated with penicillin in that zone from December 1945 to December 1947 Since January 1948 penicillin has been imported in large quantities into Western Germany a substantial part of it being allocated for the treatment of syphilis in the civilian population in the chief centres

British Zone The syphilis case rates rose from 10 per 10 000 inhabitants in the middle of 1945 to 32 per 10 000 in 1948 Since then a downward trend appears to have set in Gonorrhoea increased from 20 in 1945 to more than 50 per 10 000 in July 1946 but declined later the rates ranging from 23 to 32 per 10 000 during 1948

French Zone Syphilis reached a maximum in November 1946 with 17 cases per 10 000 inhabitants followed by a decline to 6 4 per 10 000 at the end of 1948 Gonorrhoea has also decreased at a corresponding rate from nearly 40 cases per 10 000 inhabitants in the middle of 1946 to 14 per 10 000 in 1948 The incidence varied in the different regions in 1946 the highest rates for both diseases were observed in the Palatinate the lowest for syphilis were seen in Wurttemburg and the lowest for gonorrhoea in the Saar

USSR Zone Since 1946 venereal diseases have shown a definite decline Declaration of venereal diseases of sources of infection and of names of persons likely to have been contaminated was made compulsory In March 1947 the respective incidence rates (per 10 000 inhabitants) for gonorrhoea and syphilis were 10 7 and 11 4 in Saxony and 21 9 and 31 9 in Mecklenburg Children under 14 years of age represented about 3/ of the cases of syphilis

In all the occupied zones of Germany venereal diseases penetrated into rural areas where before the war they had been very rare The rates for 1946 indicate that venereal disease was as widespread in the thinly populated rural districts as in cities such as Dresden and Leipzig

Berlin The data for the whole city as for each sector are of consider able interest and show that the maximum number of cases in both syphilis and gonorrhoea was reached in 1946 a definite downward trend was observed in 1947 — comparison with the situation immediately after the first World War shows that morbidity from venereal disease in 1919 was greater than the combined rate for the four sectors of Berlin in 1946 or 1947

Displaced Persons

Data provided by the International Refugee Organization indicate that the incidence rates for syphilis and gonorrhoea in the refugee population are considerably higher than those in the German population During the first quarter of 1948 the rates (per 10 000 inhabitants) recorded among the refugees in the American British and French zones varied, from one zone to another, between 41 and 73 for gonorrhoea and 50 and 68 for syphilis However, the part represented by this refugee population in the venereal disease problem in Germany is insignificant, as only 775 cases of syphilis and 751 cases of gonorrhoea among displaced persons were notified between January and March 1948 in the whole of the three western occupation zones

Notes and News

Important WHO Appointment

FIG 6 DR MARTHA M ELIOT
NEW ASSISTANT DIRECTOR GENERAL WHO



Dr Martha May Eliot Associate Chief of the Children s Bureau of the United States has been appointed Assistant Director General of WHO in succession to Dr N M Goodman who will return to his post as a senior medical officer at the Ministry of Health London after the Second World Health Assembly

Dr Eliot who has specialized in maternal and child health questions has been Professor of Paediatrics at Yale University and has occupied various important positions in the American administration At the present time she is a member of the Directing Committee of the National Health Council of the United States

As a result of Dr Eliot s contributions during the war to the preparation and realization of the American Government s programme

for families of mobilized men (the Emergency Maternal and Infant Care Program) and of her collaboration in government work for the welfare of children, she was awarded the Lasker prize in 1948. This distinction is awarded each year by the American Medical Association to men or women whose activities in medical research and in public health administration have contributed or will contribute to raising health standards throughout the world. Dr Eliot collaborated in the work of UNRRA, as an alternate member of the Standing Technical Committee on Health set up by the Council of that organization, while she has also rendered valuable services both to UNICEF and WHO. As United States delegate to the International Health Conference of New York in 1946, Dr Eliot was one of the signatories of the WHO Constitution, while she also represented her country at the First World Health Assembly. She was elected Chairman of the WHO Expert Committee on Maternal and Child Welfare which held its first session in Geneva in January 1949.[1]

Dr Goodman had been appointed Director of the European Health Regional Office of UNRRA in 1944. When the Interim Commission of WHO took over the functions in health formerly carried out by UNRRA, Dr Goodman was appointed Director of Field Services and in this capacity he directed all medical missions for two years. In 1948, with the definitive establishment of WHO, Dr Goodman became Director of the Division of Field Operations, and, on 1 January 1949, Acting Assistant Director-General.

Bulletin mensuel de l'Office International d'Hygiène Publique

A certain number of the issues of the *Bulletin mensuel de l'Office International d'Hygiène Publique*, some of them comprising complete years from 1913 to 1946, are still available, as well as a few isolated numbers for 1909.

Each issue of the *Bulletin* contains communications and reports on communicable diseases, a section on international conventions and on laws and sanitary regulations promulgated in various countries, an epidemiological bulletin on pestilential diseases and, finally, bibliographical analyses of articles on infectious diseases, public health and the various branches of hygiene. These studies, taken together, provide a summary of the many activities of OIHP from 1909 to 1946, and a picture of the advances made in public health during the last forty years. WHO, having inherited the functions of OIHP and continuing the work of this Organization, is including in its various publications the data formerly presented in the *Bulletin mensuel* of OIHP.

Numbers of the *Bulletin* may be obtained on application to the Office International d'Hygiène Publique, 195 Boulevard St. Germain, Paris, VII.

International Refugee Organization adopts WHO Vaccination Certificate

So as to facilitate the movement of refugees and displaced persons proceeding to their countries of resettlement, the International Refugee Organization (IRO) has just had printed a special edition comprising 250 000 copies of the International Vaccination Certificate of WHO, of which mention has been made in a preceding number of the *Chronicle*.[2] IRO has had the booklet distributed to all displaced persons who are to be resettled in various countries.

[1] *Chron. World Hlth Org.* 1949, 3, 43.
[2] *Chron. World Hlth Org.* 1948, 2, 235.

PUBLICATIONS OF THE WORLD HEALTH ORGANIZATION *

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual English and French)

This publication intended for national health administrations and for health services at ports and frontiers contains notifications concerning diseases qualified as pestilential in the International Sanitary Conventions as well as other information about the application of these Conventions

It is mainly intended for official use and is not for sale separately It can however be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below)

EPIDEMIOLOGICAL AND VITAL STATISTICS REPORT

(Bilingual English and French)

The *Report* is published monthly and contains statistics on infectious diseases mortality rates etc. *The statistical information is supplemented by various articles* and notes on epidemiological and demographic subjects

Subscription for 1949	25/	$5 00
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Annual subscription including the *Epidemiological and Vital Statistics Report* and the *Weekly Epidemiological Record* for the use of libraries medical schools etc £2 $8 00

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(*Separate editions in* English and in French)

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Schistosomiasis mansoni a survey of its distribution in Brazil João Alves MEIRA

Complete analysis of the specific antigen of the cholera vibrio and its practical applications. J GALLUT

On the standardization of the methods of assaying and testing staphylococcus toxoid. P MERCIER & J PILLET

On standardization of diphtheria toxoid some theoretical and practical considerations N K. JERNE & O MAALØE

Tetanus toxin and antitoxin *Department of Biological Standards National Institute for Medical Research London*

Dextro-tubocurarine chloride a provisional British standard. *Department of Biological Standards National Institute for Medical Research, London*

Standardization of the cobra *(Naja flava)* antibody a comparative study by the method of assay at various levels and by the selected antivenene single-level method E. GRASSET

Venereal diseases in Ethiopia survey and recommendations T GUTHE

International control of venereal disease excerpts from the report on the second session of the Expert Committee on Venereal Diseases

Price 7/6 $1.50

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

(Published in English, French, Spanish, Russian and Chinese) Monthly publication

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VOL. 3 No 6 JUNE 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VENEREAL-DISEASE CONTROL AMONG RHINE RIVER BOATMEN

Preparatory Meeting for the Setting up of an International Commission

The co ordination of venereal disease control in the Rhine area advocated by the International Union against Venereal Diseases and recommended by the WHO Expert Committee on Venereal Diseases [1] is a new aspect of international co-operation in venereal disease control The Brussels Agreement of 1924 respecting facilities to be accorded to merchant seamen for the treatment of venereal disease ratified and adhered to by 56 signa tories has been shown to be a useful but nevertheless limited instrument in ensuring the success of venereal disease control on an international scale In spite of various efforts to standardize venereal-disease therapy to obtain uniform interpretation of the results of serological examinations and to establish treatment centres in ports the medical supervision of seamen and the application of ambulatory treatment are rendered difficult by the fact that every country applies its own methods and its own legislation both in the medical and the social spheres Such difficulties are parti cularly striking in the case of the Rhine river boatmen who represent a population of some 80 000 — boatmen and their families — journeying on the Rhine its tributaries its canals and the water-courses connected with them calling at ports in five different countries and never staying more than a few days in the same port Their wandering existence exposes these boatmen to contagion and through lack of effective care they may become active factors in the spread of venereal diseases

Following the setting up in 1936 by the International Union against Venereal Diseases of a Rhine River Sub-Committee plans were considered

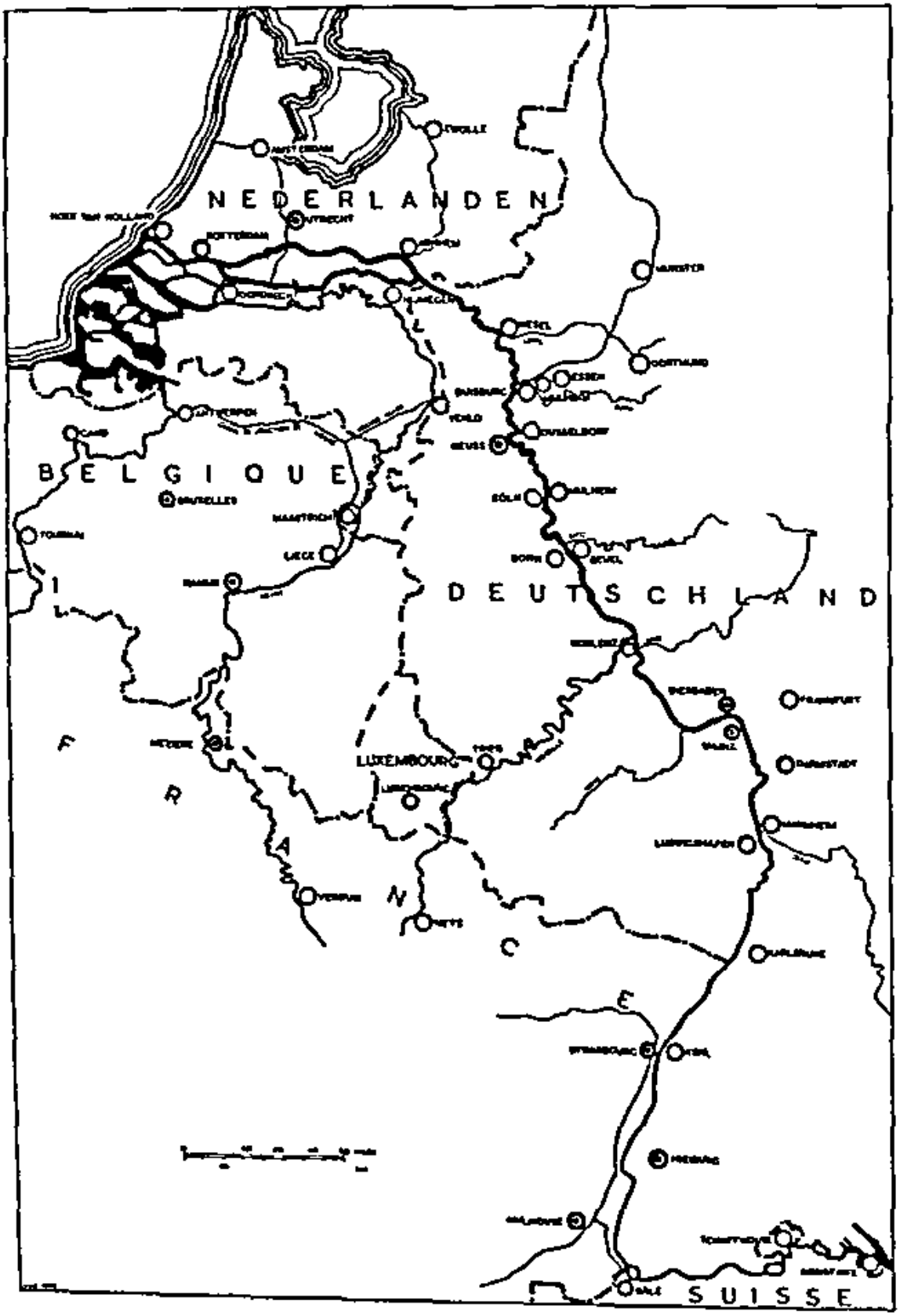
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FIG 1 MAP OF THE RHINE RIVER AREA



to co ordinate the measures taken by the various countries concerned with venereal disease control among Rhine river boatmen The war, however interrupted this work

The original plans were reconsidered, and a new programme proposed at a preparatory meeting convened by WHO, for the establishment of an international commission for venereal disease control in the Rhine area, held in Geneva from 30 May to 1 June 1949 Representatives from Belgium, France the Netherlands Switzerland and the American, British and French zones of occupation in Germany — accompanied by German public health officials — participated in the meeting as well as observers from the International Labour Organization the Central Rhine Commission and the International Union against Venereal Diseases

The conference, after noting the present position and the facilities already existing in the larger Rhine ports recommended that the facilities accorded to boatmen should be extended and developed by the following measures

(*a*) Establishment of diagnosis and treatment centres in the principal river ports which do not as yet possess them

(*b*) free medical examinations, treatment and hospitalization not only for nationals of the country concerned, but also for foreigners not only for seamen and boatmen but also for their families living on the boats

(*c*) development or creation of social services preferably specialized so that epidemiological action can be taken and social assistance given to patients,

The following were present

Belgium
Dr P van de Calseyde Directeur général de l Hygiène Ministère de la Santé publique et de la Famille Brussels

France
Professeur L M Pautrier Professeur honoraire à la Faculté de Médecine Strasbourg

Netherlands
Dr E H Hermans, Associate Professor of Dermato-Venereology Rotterdam

Switzerland
Dr R Schuppli Privat-docent à la Clinique de Dermato-Syphiligraphie de l Université de Bâle

Germany
Dr M Chaton Service de Santé Baden Baden (French Zone of Occupation)
Major-General J G Gill Chief Public Health Officer Land Public Health Department Land North Rhine/Westphalia Dusseldorf (British Zone of Occupation)
Dr W D Radcliffe Chief Public Health Branch *Office of Military Government for Württemberg* Baden Nuremberg (American Zone of Occupation)
Frau Dr Lange Public Health Administration of Westphalia
Dr A Ungr *Public Health Commissioner Württemberg*

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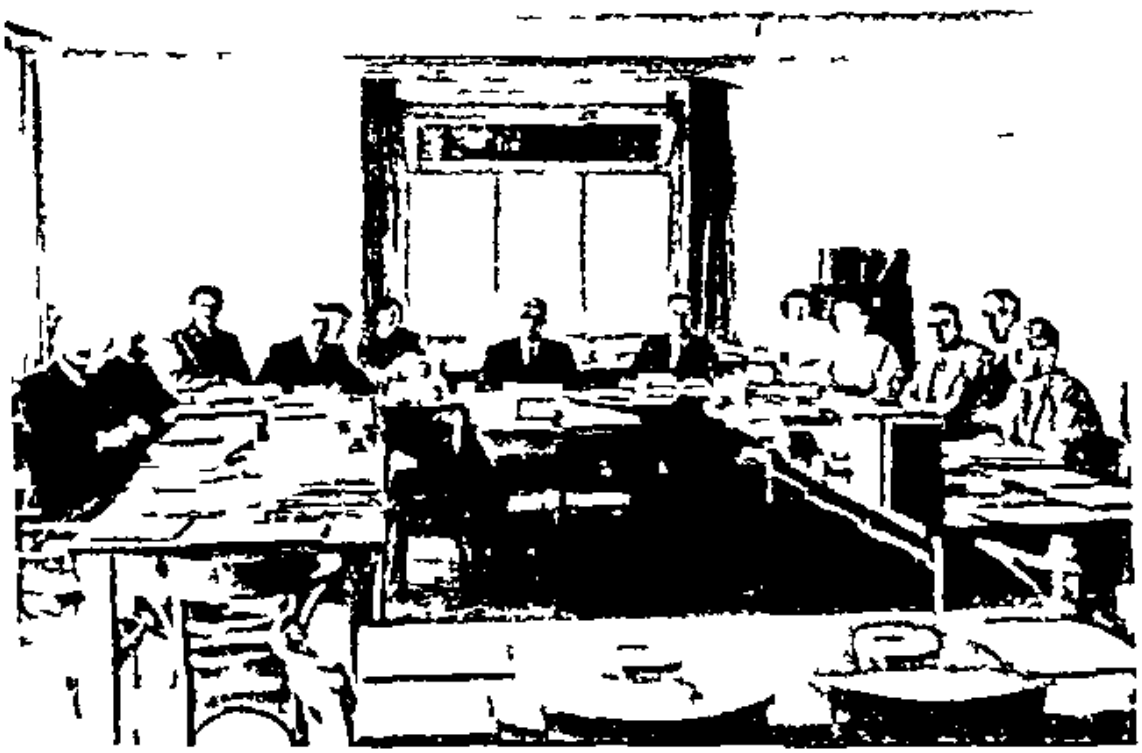
Central Rhine Commission
M C Bonet Maury Commissaire suppléant de la France Strasbourg

International Union against Venereal Diseases
Dr A J Cavaillon Directeur général de la Santé Ministère de la Santé publique et de la Population Paris

WHO
Dr W Bonne Director Division of Planning
Dr T Guthe Chief Venereal Diseases Section
Dr A Spillmann Venereal Diseases Section

tests quantitative tests for lead limit tests for heavy metals limit tests for arsenic A table of usual and maximal doses for commonly used drugs was revised and a study was made of the means to be used if necessary for preventing the renewal of a prescription containing a dose in excess of the maximal dose The committee had also to decide upon the choice of a title for the work now nearly ready for publication and the

FIG 2. EXPERT COMMITTEE ON UNIFICATION OF PHARMACOPOEIAS FOURTH SESSION



L ft to right (seated o d t ble) E F llerton Co k P otesso H Baggesg d Ra mussen I t p ete P otesso R Haza d D C H H mpshi e (Cha rman) P Bla c (WHO) Mm B La g Porchet (WHO) Profes o I R. F hmy Profe sor D an Os Prof sso H Fl ck

majority of the members was in favour of the title International Pharmacopoeia The work will therefore bear this title when it is submitted to the Executive Board and the World Health Assembly

Relations with Other Expert Committees

The committee decided to submit to the Expert Committee on Biological Standardization the monographs on sera antitoxica and to ask the advice of this committee on the methods for the biological assay of certain vegetable drugs

The problem of new antimalarial drugs which should be included in the Pharmacopoeia will be examined by the Expert Committee on Malaria at

(*d*) international tracing of infectious contacts through the exchange of epidemiological information

(*e*) distribution to patients free of charge, of an individual treatment card issued by WHO in four languages (German English French and Dutch) and drawn up in accordance with the model prescribed by the Brussels Agreement

(*f*) distribution to seamen of a folder giving a list of diagnostic and treatment centres

The conference recommended the setting-up under the auspices of WHO of a local venereal-disease commission to be called the Anti Venereal Disease Commission of the Rhine A centre of administrative liaison with the Central Rhine Commission should be set up in Strasbourg to control the international traffic on the river while a centre for technical medico-social activities should be formed in Rotterdam

UNIFICATION OF PHARMACOPOEIAS

The fourth session of the Expert Committee on the Unification of Pharmacopoeias held in Geneva from 20 to 30 April 1949 [1] was of particular importance in view of the decisions taken for the publication of the first edition of the International Pharmacopoeia which was planned for 1949

As with previous sessions the work was devoted mainly to the study of monographs reports on monographs presented by members of the committee, and general notices and appendices intended to be published in the first edition Most of the 190 monographs were definitively accepted by the committee a few being left to the Chairman and the Secretariat for minor changes The texts of the following appendices were also adopted reagents test solutions solutions for volumetric determinations identification

[1] The following were present

Members

Professor H Bagtesgaard Rasmussen, Chairman, Chemical Division, Danish Pharmacopoeia Commission, Copenhagen, Denmark

E. Fullerton Cook, M.Sc., Chairman, Committee of Revision of the Pharmacopoeia of the United States of America, Philadelphia, Pa USA

I. R. Fahmi Ph.D., Professor of Pharmacognosy Fouad I University Cairo, Egypt Secretary Egyptian Pharmacopoeia Commission

H. Flück, Dr Sc. Nat., Professor of Pharmacognosy Eidgenössische Technische Hochschule Zürich, Switzerland Membre de la Commission fédérale de la Pharmacopée

Dr C. H. Hampshire, Secretary British Pharmacopoeia Commission, General Medical Council Office, London, United Kingdom *(Chairman)*

Dr R. Hazard, Professeur de Pharmacologie et de Matière médicale à la Faculté de Médecine de l'Université de Paris, France Membre de la Commission du Codex

Professor D. van Os, Professor of Pharmaceutical Chemistry and Technology University of Groningen Chairman, Netherlands Pharmacopoeia Commission, Groningen, Netherlands

Secretary

[illegible], Division of Therapeutic Substances, WHO

tests quantitative tests for lead limit tests for heavy metals limit tests for arsenic A table of usual and maximal doses for commonly used drugs was revised, and a study was made of the means to be used if necessary for preventing the renewal of a prescription containing a dose in excess of the maximal dose The committee had also to decide upon the choice of a title for the work now nearly ready for publication and the

FIG 2. EXPERT COMMITTEE ON UNIFICATION OF PHARMACOPOEIAS FOURTH SESSION



Left to right (seated d tabl) E. Fullerton Co k Professo H B ggesgaa d Rasm se I terpret Professor R. H za d D C H Hampshi (Cha rman) P Bl (WHO) Mme B La g Porchet (WHO) P ofesso I R Fahmy P of ssor D van Os P fesso H Fl ck

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The problem of new antimalarial drugs which should be included in the Pharmacopoeia will be examined by the Expert Committee on Malaria at

its next session Draft monographs on a few of these drugs have already been prepared

The committee considered the recommendation of the Expert Committee on Habit forming Drugs which was referred to it by the Executive Board concerning the giving of a common name to new drugs likely to be placed under international supervision The members of the committee indicated that they were prepared to supply names for such drugs

It was proposed that the committee should meet again at the end of September 1949, in order to make a final examination of the monographs and appendices which would make up the first edition of the *International* Pharmacopoeia

THE DECLINING DEATH-RATE

The statistical data collected by WHO shows clearly that, in spite of the destruction and disturbances caused by the second World War, the downward trend of the general death rate already apparent in 1946,[1] continues almost everywhere In what may be called the 'world registration area', *i e* the countries for which vital statistics are available the death rate is at present the lowest ever known This phenomenon which is as satisfactory as it is surprising is analysed by Mr K Stowman, Epidemiological Consultant to WHO, in a recent article in the *Epidemiological and Vital Statistics Report*

"This does not necessarily signify writes Mr Stowman that health conditions are ideal, but simply that the forces which have operated for more than half a century in producing this trend remain active enough to overcome the adverse factors set in motion by the second World War It should not be overlooked however that adequate mortality data are lacking for a large proportion of the world s population and that conditions of life are known to be unfavourable in a large part of this non registration area

Present Position in Europe

As far as Europe is concerned, the data concerning the countries for which statistics are available have been condensed by the author in a table which is reproduced, with certain modifications as table I It will be

[1] *Ch on World Hlth O g* 1947 1 187
[2] *Epidem vital Stat Rep* 1948 1 412

TABLE I GENERAL MORTALITY (RATES PER 1 000 INHABITANTS CALCULATED ON AN ANNUAL BASIS) IN EUROPE 1937 1939 AND 1946 1948

Countries	Death-rates in			Variation from 1937 1939 to 1947		Death rates for part of the year			Variation from 1947 to 1948	
	1937 1939	1946	1947	rate	%	Number of months	1947	1948	rate	%
Australia	14 2	13 4	13 0	— 1 2	— 8 5	9	13 2	11 7	— 1 5	— 11 4
Belgium	13 4	13 6	13 3	— 0 1	— 0 7	8	14 0	12 4	— 1 6	— 11 4
Bulgaria	13 6	13 7	13 4	— 0 2	— 1 5					
Czechoslovakia	13 2	13 8	11 9	— 1 3	— 9 8	8	12 3	11 3	— 1 0	— 8 1
Denmark	10 4	10 2	9 7	— 0 7	— 6 7	8	11 2	9 3	— 1 9	— 17 0
Finland	13 6	12 0	11 9	— 1 7	— 12 5	8	12 4	11 3	— 1 1	— 8 9
France	15 2	13 3	13 0	— 2 2	— 14 5	6	14 6	12 7	— 1 9	— 13 0
Germany										
American Zone			12 2			6	13 7	12 0	— 1 7	— 12 4
British Zone	11 3	12 3	11 3	—	—	6	12 0	9 9	— 2 1	— 17 5
French Zone	11 9 [b]	13 2	12 8	+ 0 9	+ 7 6	7	13 6	12 2	— 1 4	— 10 3
Hungary	14 0	14 7	12 4	— 1 6	— 11 4	9	12 6	11 2	— 1 4	— 11 1
Iceland	14 4	14 0	14 9	+ 0 5	+ 3 5	9	16 0	12 4	— 3 6	— 22 5
Italy	13 9	12 0	11 3	— 0 6	— 18.7	7	12 1	10 3	— 1 8	— 14 9
Malta	20 1	13 9	13 0	— 7 1	— 35 3	6	11 8	11 7	— 0 1	— 0 8
Netherlands	8 6	8 5	8 1	— 0 5	— 5 8	9	8 2	7 2	— 1 0	— 12 2
Norway	10 2	9 3	9 3	— 0 9	— 8 8	6	10 2	9 1	— 1 1	— 10 7
Portugal	15 5	14 7	13 3	— 2 2	— 14 2	9	12 9	12 3	— 0 6	— 4 7
Roumania	19 0	18 0	21 1	+ 2 1	+ 11 1					
Spain	15 1	12 8	11 8	— 4 3	— 8 7	8	12 3	11 0	— 1 3	— 10 6
Sweden	11 7	10 5	10 8	— 0 9	7 7	6	11 9	10 3	— 1 6	— 13 4
Switzerland	11 6	11 3	11 3	— 0 3	— 2 6	9	11 5	10 7	— 0 8	— 7 0
United Kingdom	12 2	11 7	12 1	— 0 1	— 0 8	9	12 5	10 7	— 1 8	— 14 4

Excluding infants live born but dying before registration [b] 1939 1934 1938

seen that, in almost all these countries, the death rate in 1947 was definitely lower than that for the period 1937-39, when the demographic situation had not yet been affected by military operations It is a remarkable fact that these low rates were achieved in spite of a relatively poor health situation in a number of countries An increase in the death rate compared with the period immediately preceding the war, was found only in the French zone of occupation in Germany in Ireland and in Roumania The two last named countries are also those in which the death rate is still highest in Roumania the rate for 1947 (21 1 per 1,000 inhabitants) is the highest recorded for 15 years, it greatly exceeds that for any other European country appearing in the table

The incomplete data for 1948 which were available to the author when his study was made — data referring to a variable number of months — show that the downward trend has been maintained, for the year as a whole rates still lower than those for 1947 may be generally expected

It is in the Latin countries of southern and western Europe that the recent reduction in mortality has been most marked France, Mr Stowman points out, " which until the last two years has never had a death rate under 15 per 1,000, had a rate of 13 0 in 1947, and the rate may be still lower in 1948 The death rate of Italy is now as low as that of Switzerland and lower than that of the United Kingdom The death rate for Spain is almost as low, but is somewhat understated because infants dying before being registered as births continue to be registered as stillbirths The death rate of Portugal is now down to the level of that of Belgium An extraordinary reduction in mortality is observed in Malta where the general death rate was 13 0 in 1947 although until the war it had only once fallen below 20 per 1,000

" Thus the Latin area of Europe which before the war had death rates ranging from 14 to 20 now has rates from 11 to 13 per 1,000 The result is a greater homogeneity in mortality in Europe which must be the con sequence of a progressive levelling out of the causes determining the force of mortality

This tendency towards greater uniformity in the death rate is also apparent in other parts of Europe particularly in the Balkans The case of the Netherlands is remarkable from quite another point of view this country has the lowest death rate in the world The rate for the whole of the year 1948 will probably be less than 8 per 1 000 inhabitants after having been 6 2 in August It had never previously been considered possible to attain such low general death rates in a population of nearly ten millions without striking peculiarities in regard to economic or age constitution

The fluctuations in the mortality curve during the years 1945 to 1948, in a few countries affected by the war can also be seen from the graph reproduced in fig 3

Effect of the Age Distribution of the Population

The recent evolution of birth rates previously investigated by Mr Stowman [3] tends to reduce the differences which existed between the various parts of the continent and therefore to equalize the population pressure In order accurately to appraise this phenomenon a factor which unfortunately is only too often neglected must be taken into account the considerable influence which the composition by age of a given population exercises on the general death rate and which it may continue to exercise for many years To illustrate the importance of this factor the author gives the following example

In Denmark in 1941 1945 the death rate for the population of ages 1 39 years was 1 9 per 1 000 while the rate for the remainder of the population was 23 1 The general death rate was 10 1 per 1 000 The population from 1 to 39 years of age made up 61 5 / of the total Had only 59 7 / of the population been of those ages as was the case in France at the 1936 census the general death rate would have been 10 4 per 1 000 or 3 / higher

It will be seen that a comparatively slight change in the distribution by age groups of the population can by itself bring about an increase or a decrease in the general death rate A mere comparison of crude general death rates does not therefore give a true picture of the situation when appreciable variations occur in the composition by age of the various populations In order to overcome this difficulty recourse is had to standardized rates *i e* to rates as they would appear if all populations had the same composition by age

Standardized rates were calculated before the war for most European countries and for a few countries outside Europe adopting as a standard the population of England and Wales in 1901 For all European countries the rates thus standardized for certain years between 1930 and 1938 are lower than the corresponding crude rates the differences varying between 12 / for Hungary and 33 % for Sweden These relatively wide divergencies are due to the fact that the true composition of the different populations became further and further removed from that of the standard population used as a basis on account of the gradual and general ageing of the population incidentally they serve to emphasize the necessity for adopting in future a standard population closer to the present average This ageing has become more rapid during the last ten years even in countries which escaped the war or which were but little affected by it In Denmark for example the population 60 years of age and over increased 22 / from 1935 to 1945 while the low death rate group from 10 to 29 years decreased

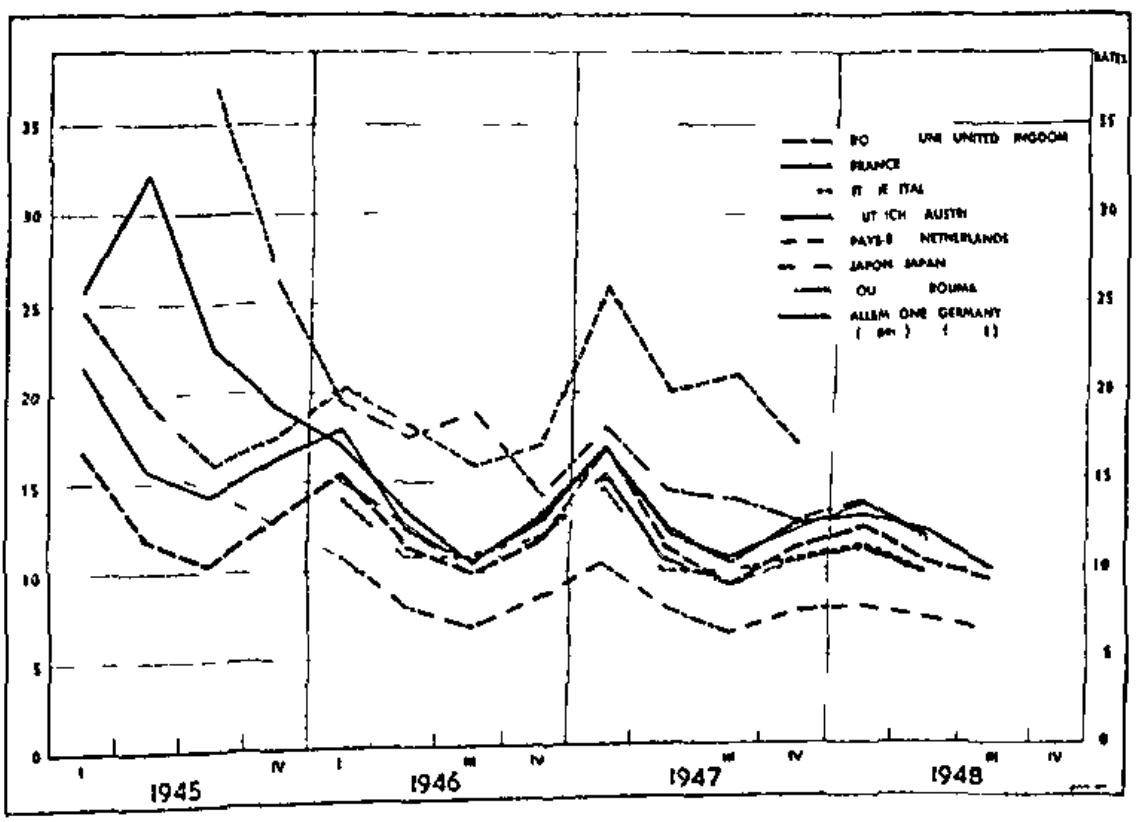
5% At the same time the high death rate population under 2 years of age increased 43 5 %

'The effect of this evolution [from 1935 to 1945] can be measured by standardizing the 1945 death rate on the basis of the 1935 age distribution The result was an age adjusted 1945 death rate of 9 6 per 1 000 as against a crude death rate of 10 5 The fall of the death rate for Denmark from 1935 to 1945 was therefore not from 11 1 to 10 5 as indicated by the crude rates but to 9 6 In other words, there was a reduction of 14% instead of the apparent 5%

Causes of the Decline

From the foregoing it appears that the true decline in general mortality which has taken place in Europe during these latter years is even more

FIG 3 GENERAL MORTALITY IN CERTAIN COUNTRIES AFFECTED BY THE WAR



Quarterly rates per 1 000 inhabitants calculated on an annual basis For the Netherlands for 1945 the annual rate is used

marked than is indicated by the crude rates This decrease the causes of which are not obvious may be attributed but in part only to the progress accomplished in epidemic control and the control of disease in general

However only after a detailed study of the data concerning causes of death — data which WHO is at present endeavouring to collect — will it be possible to form a true estimate of the real and underlying causes of the improvement which has taken place in the outlook for human longevity

After reviewing in detail the mortality situation in the various countries outside Europe for which reliable figures are available and noting that a similar evolution is taking place there to a varying extent — decline of the death rate and gradual ageing of the population — the author concludes as follows

To summarize we see that death rates still vary from 8 to over 30 per 1 000 population in different countries even when war casualties are ignored These differences would be still greater if the rates were standardized for age distribution of population The inequality before death therefore persists Nevertheless during the last two years the trend of mortality has been strongly downward in nearly all countries for which we have reliable information Help extended across national frontiers whether in materials or in assistance or simply by spread of new knowledge has certainly something to do with the granting of additional years of life What other forces are at work can be determined only by a thorough analysis of detailed post war mortality data which should become available within a not too distant future

INFLUENZA EPIDEMIC OF 1948/49 IN EUROPE

From the beginning of 1947 to October 1948 Europe was practically free from influenza epidemics although a mild form of the disease had been prevalent during the first half of 1948 in Greece Sardinia Sicily and a few areas of Italy In October 1948 however a real epidemic originating in Sardinia spread slowly to most European countries

Spread of the Disease

Epidemiological clinical and bacteriological data collected by WHO have enabled Dr G Stuart Chief of the Sanitary Conventions and Quarantine Section to review in a recent article in the *Epidemiological and Vital Statistics Report*[1] the evolution and characteristics of the outbreak The

[1] *Epidem al S R p* 1949 2 4

author studies its development in various parts of Europe where it was prevalent in varying degrees of severity while apparently leaving Albania Hungary Denmark Norway and Sweden untouched The spread of the disease from Italy to France and Switzerland then to Austria Bulgaria and the Netherlands from October 1948 to the middle of January 1949 has been described in a previous number of the *Chronicle* [2] The British Isles were not affected until January and it was not until the first week of February that deaths from influenza including influenzal pneumonia began to rise significantly in the large towns of England and Wales In any case the disease did not assume the proportions of an epidemic and did not affect all parts of the country A few cases appeared at the end of January in the northern provinces of Spain and in Finland At the beginning of February, Turkey reported sporadic cases within its territory and on the 19th of the same month widespread occurrence in Ankara and Istanbul Western Anatolia was also involved During February the number of cases greatly increased in the US Occupation Zone in Germany

Clinical Form

Dr Stuart points out that the clinical form of influenza observed during the epidemic was generally mild The disease lasted between four and seven days and was followed by a state of debility necessitating a lengthy convalescence Complications and serious even fatal cases were observed among young children among the aged and among persons suffering from concomitant diseases Various countries have reported complications such as localized broncho pneumonia otitis a few cases of encephalitis and particularly in children under two years of age acute pulmonary oedema during the first 36 hours of illness

Effect on Mortality

It is particularly interesting to ascertain to what degree the epidemic influenced mortality rates in the different countries Reliable statistics are available for only two countries Italy and France in both of which the disease was particularly widespread These data show that in spite of its mild character the epidemic had repercussions on the general mortality rate and on the mortality rate from broncho pulmonary infections Thus for Italy for the month of December 1948, as compared with the same period in 1947, the general mortality rate increased by 27% and the mortality from broncho pulmonary infections by 129% In France rates varied

[2] *Chron World Hlth Org* 1949 3 11

from one department to another but it is possible to state that during the first ten days of January 1949 the increase in general mortality approximated to 30 / over that for the same ten-day period in January 1948

Virology

The virus responsible for the epidemic was identified in various institutes and Dr Stuart gives the results of investigations carried out in England at the World Influenza Centre which examined English as well as a French and two Dutch strains which had been sent to it [3] in Germany (US Occupation Zone) at US Army 4 Medical Laboratory in France at the Institut Pasteur Paris in Italy at the Medical Clinic of the University of Rome and at the Institute of Hygiene of Palermo in the Netherlands at the Virus Laboratory of the Clinic of Internal Medicine of the University of Leyden in Switzerland at the Institute of Hygiene of the University of Berne and in Turkey The results of these investigations are close enough to justify the statement that the influenza epidemic of 1948/49 was caused by a strain of virus A related to the variety 1947 A (American FMI) which caused the 1947 epidemic but only remotely related to the earlier strains of virus A (PR8 and Weiss)

In concluding his analysis of the data on the influenza epidemic the author quotes the conclusion reached by the US Commission on Acute Respiratory Diseases (1948)

Influenza A and B are endemic diseases which periodically erupt in explosive form the virus persisting between epidemic periods by case to-case transfer

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves Selections from these reports have therefore been published from time to time but it must be emphasized that the opinions expressed are those of the Fellows

Cardiology in France and the United Kingdom

Dr R Ivančic of Zagreb a heart specialist has spent a year in France and the United Kingdom visiting institutes and clinics specializing in heart diseases The following observations have been taken from his report

Dr Ivančić chose Paris and Edinburgh for his study as he wished to learn something of medical schools other than the German school the influence of which had been predominant before the war in the university in which he had studied His studies in these two cities enabled him to become familiar with developments in cardiology during the last few years and to study modern teaching methods He was able to attend demonstrations as well as postgraduate courses

In Paris Dr Ivančić worked at the clinic of Professor Lian in Professor Laubry s section and that of his students Lenègre and Soulié as well as in Professor Donzelot s clinic Each of these clinics writes Dr Ivančić has its own special field of work and together they constitute a most valuable entity Professor Lian s clinic is in particular noted for its excellent methods of clinical diagnosis and for its sections dealing with electrocardiography and phonocardiography All current problems of cardiology are studied especially congenital heart diseases hypertension and bacterial endocarditis Because of the large number of patients treated in this clinic the student may become familiar with many different forms of heart disease and acquire a wide experience of electrocardiographic phonocardiographic and electrokymographic techniques

Professor Donzelot s clinic which is housed in a modern building is equipped with the latest instruments Several well known specialists are in charge of the different services with the result that this centre is of the greatest importance in the study of heart diseases Professor Donzelot specializes in endocarditis and has achieved an extremely high rate of recovery (75/) Dr Gaudart d Allaines has performed surgical operations with results comparing most favourably with those obtained in modern American clinics

Dr Ivančić was particularly impressed with the work of Dr Hein de Balzac the well known teacher who specializes in radiographic examination of the heart and with that of Dr Milanovich head of the research section The latter has introduced an electro-vectocardiograph of his own invention which has proved most useful in the diagnosis of myocardial lesions

In Edinburgh Dr Ivančic spent some time at Professor Gilchrist s clinic He attended a large number of heart operations carried out by Professor Marsa and at the Western General Hospital observed the work of Dr Logan a chest surgeon whose teaching Dr Ivančić believes was invaluable for all those specializing in this subject

The author of the report concludes "The knowledge which I gained during my study tour will enable me to modernize the clinic in my own country where I am working. I am convinced that it will be possible to introduce there many of the modern methods which I have studied abroad I hope in particular to be able to organize a cardiology centre complete with a modern electrocardiographic section It will also be essential to organize lectures for my colleagues who have not had the good fortune to obtain a fellowship "

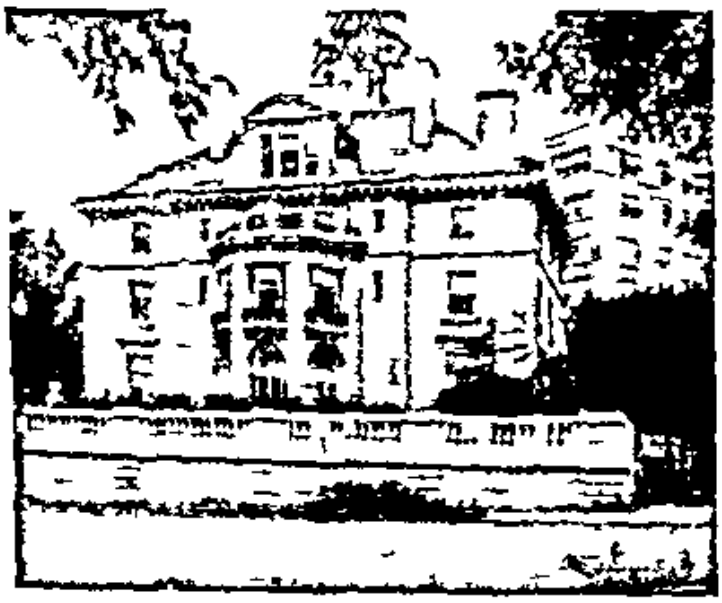
Notes and News

Integration of Pan American Sanitary Organization with WHO

The ratification of the WHO Constitution by Uruguay on 22 April 1949 brought the number of Member States to 62, and the number of Member States of the Pan American Sanitary Organization (PASO) now belonging to WHO to 14 The requisite number of ratifications by States of the American continent was thus attained for the conclusion of the final Agreement on the integration of the Pan American Sanitary Organization with WHO

This Agreement was signed at Washington on 24 May 1949 by Dr Brock Chisholm, Director-General of WHO and Dr F L Soper Director of the Pan American Sanitary Bureau

FIG 4 HEADQUARTERS OF THE PAN AMERICAN SANITARY BUREAU WASHINGTON D C



Under the terms of this Agreement the Pan American Sanitary Organization becomes a regional organization of WHO The Pan American Sanitary Conference which is the legislative body of PASO will keep its name and will also be called a WHO Regional Committee The Pan American Sanitary Bureau retains its present name with the addition of Regional Office of WHO Dr Soper will have the title of Regional Director of WHO as well as Director of the Pan American Sanitary Bureau.

The Agreement stipulates that the Pan American Sanitary Conference may promote and draw up health programmes and may adopt sanitary conventions for the American continent, provided that such programmes and conventions are compatible with the policy and general programmes of WHO and that the health programmes are financed separately It is also stated that an adequate proportion of the WHO budget will be allocated *for regional* work

In his speech delivered after the signature of the Agreement the Director General of WHO praised the work accomplished by the Pan American Sanitary Organization He indicated the main lines of the WHO programme for 1950 and emphasized the importance of the role to be played by the regional organizations In fact although certain problems such as biological standardization and the unification of pharmacopoeias will remain within the province of the Headquarters Office technical services and advice to governments will be handled by the regional organizations

Dr Chisholm said he was convinced that the countries of Latin America could furnish valuable assistance to countries whose health services were less developed than their own

Tuberculosis

WHO consultant in the Eastern Mediterranean Region

Dr B Papanikolaou Assistant Professor of Tuberculosis University of Athens Greece is at present visiting certain countries in the Eastern Mediterranean region He has completed surveys in Aden and Saudi Arabia is now working in Lebanon and Syria and will shortly be visiting Cyprus Dr Papanikolaou is in charge of the Chest Institute Athens and has been responsible for the major part of the work in connexion with mass x ray examinations in Greece during recent years

WHO and UNICEF consultants in Central and South America

Dr Gumersindo Sayago Director of Medical Social Assistance for the Tuberculous, Córdoba Argentina who visited the Philippines in 1948 as tuberculosis consultant to the medical teaching mission sponsored jointly by WHO and the Unitarian Service Committee of America [1] and Dr I M Lourie of the WHO Secretariat Geneva are at present undertaking surveys in Central America

In South America Dr O M Mistal Geneva Switzerland author of a number of important works on tuberculosis is working with Dr Gyllenswärd Professor of Paediatrics University of Upsala Sweden It is hoped to collect much valuable information on the present and future needs in respect of antituberculosis services in these countries and to ascertain their probable requirements in connexion with BCG vaccination Dr Lourie and Dr Gyllenswärd who have both had special experience in BCG vaccination will report to the joint enterprise which is responsible for the field work in this area

WHO consultant in South East Asia Region

Dr E Mayer New York a member of the Trudeau Society USA has returned from a brief visit to India and Ceylon where he has been advising on tuberculosis problems His report will shortly be submitted to the Director of the WHO Regional Office for South East Asia and to the Director General of WHO

WHO consultant on streptomycin

Dr H Wissler Davos Platz Switzerland formerly assistant to Professor G Fanconi Zurich is now in Poland and will proceed to Czechoslovakia Hungary and Yugoslavia to interview workers on streptomycin therapy in those countries Supplies of streptomycin are being sent to a number of countries in Europe and the function of the WHO consultant is to correlate the work and to endeavour to obtain some degree of uniformity in reporting the results obtained

[1] *Ch on World Hlth Org* 1949 2 63

Radiology in Egypt

As a result of a report submitted to the Egyptian Government in January 1949 by a WHO tuberculosis specialist a request was received for the services of an x ray technician to assist in the inauguration of mass x ray examinations in Egypt. Mr C. Ashwin formerly Radiological Technician Portsmouth England is at present in Egypt and has started work in Megalla-el Kobra, where important industrial developments have taken place in recent years

Venereal Diseases

WHO expert consultant in the Western Pacific region

Dr J Amador Guevara, Director-General, Anti Venereal Disease League, San José Costa Rica, who was a member of the medical teaching mission sponsored jointly by WHO and the Unitarian Service Committee of America which recently visited the Philippines,[2] has been appointed WHO temporary expert consultant in venereal diseases for the Western Pacific region At the request of the Philippine Government he will continue his activities in Manila until July The Philippine public health authorities have developed a venereal-disease control programme organized training courses for technical personnel and have planned a joint yaws-syphilis demonstration scheme

WHO expert consultant for Europe

Dr A. Spillmann Médecin Inspecteur de la Santé de la Seine Paris, who has been appointed WHO consultant in venereal diseases for Europe took up his duties on 1 March 1949 In January he made official visits to Rome Palermo Naples Syracuse and Catania in connexion with a proposed WHO demonstration programme in Italy the plans for which are now being studied In April he attended the congress of French speaking syphilologists in Brussels In May he visited Roumania to discuss the WHO/UNICEF assistance in connexion with the venereal-disease campaign to be organized in that country

Lectures in Austria

In January at the request of the Austrian Government, Dr G L M McElligott, Adviser on Venereal Diseases Ministry of Health, London and member of the WHO Expert Committee on Venereal Diseases, lectured at the Universities of Graz, Innsbruck and Vienna.

Campaigns in Bulgaria Czechoslovakia, Hungary and Yugoslavia

Dr E Thomas Professor of Clinical Medicine New York University College of Medicine and Director Rapid Treatment Centre Bellevue Hospital New York has recently visited Bulgaria Czechoslovakia, Hungary and Yugoslavia in connexion with the anti venereal-disease campaigns launched by health administrations in these countries with the material aid of UNICEF and the technical advice of WHO

Lectures by Dr Thomas at the Universities of Budapest and Pecs were attended by more than 200 physicians from the whole of Hungary Under the venereal-disease control programme now being developed in Hungary the distribution of penicillin will be controlled from Budapest. In Yugoslavia, where a full programme was also arranged for Dr Thomas, the professors of dermato-syphilology for all the republics and the heads

of most of the venereal disease clinics throughout the country attended a conference in Belgrade to discuss technical aspects of the anti venereal-disease campaign Considerable discussion took place on the treatment schedules to be used particularly in the area in Bosnia Herzgovina in which syphilis is endemic. It is essential that only one schedule be used in each country but general agreement on the schedule to be adopted cannot always be readily obtained Some opposition to penicillin treatment exists in most European countries and was noticeable in those visited most of the difficulties however have been successfully overcome

Venereal-disease control in Czechoslovakia

A request has been received from the Czechoslovak health authorities that the Slovak programme of venereal-disease control be expanded into a nation wide campaign An expert consultant from WHO is discussing the programme with the health authorities in Prague

Expert consultant in Roumania

Preparations are being made to meet the request of the Roumanian Government for an expert consultant to discuss a nation wide venereal-disease control programme in which UNICEF and WHO would participate

Model treatment schedules

WHO has made arrangements for the establishment of model treatment schedules, based on the treatment of early syphilis with procaine penicillin in oil and aluminium monostearate at the municipal clinic in Copenhagen (Dr F Marcussen) and the university clinics in Stockholm (Professor S Hellerstrom) and Oslo (Professor N Danbolt) Further demonstrations are being established at the municipal clinic in Rotterdam (Dr E. H Hermans) and in Paris at the Hôpital St Louis (Professor H Gougerot) Penicillin for these demonstrations is being provided free of charge by the American pharmaceutical industry and in January supplies were received in Copenhagen Stockholm and Oslo Similar demonstrations may also be established in other European clinics

Evaluation of serological tests

Arrangements have recently been completed to include Naples (Professor Carlifanti) and Helsinki (Professor Renkonen) in the scheme for evaluating the performance of serological tests

Venereal-disease control in India

Experts from WHO in venereal-disease control have recently left for India They have been sent to demonstrate the treatment of syphilis with penicillin and to make final arrangements with the Indian health authorities and with Dr C. Mani Director of the WHO Regional Office for South East Asia for setting up diagnostic laboratories and organizing advanced courses for doctors nurses and Indian laboratory assistants

Dr J Cutler of the US Public Health Service formerly Director of the Venereal Disease Research Laboratory of the Pan American Sanitary Bureau in Guatemala is heading the group of experts He is accompanied by Dr J Kvittingen of the Bacteriological Institute of the Rikshospital Oslo who was responsible for the organization of the first centre for venereal-disease treatment set up in the United Kingdom during the war for Norwegian seamen and by Miss M Slight superintendent of nurses Topeka USA

Malaria Control in Europe and Asia

Malaria control campaigns have been undertaken in Bulgaria Hungary and ugoslavia with the material assistance of the United Nations International Children s Fund (UNICEF) which provides the necessary supplies and the technical - of WHO which provides the governments concerned with experts

FIG 5 MALARIA CONTROL IN YUGOSLAVIA



Sea chi g to mosq ito s i th estu ry of th Ne tva R ver

Professor A. Missiroli, WHO expert consultant, Mr P Bierstein, WHO sanitary engineer M C Toumanoff entomologist from the Institut Pasteur Paris and Mr K. Schulz, from the Union of South Africa, were charged with missions in these countries It will be recalled that in Hungary an increase in the prevalence of malaria has been observed during the last few years In Yugoslavia a wave of malaria spread over the country in 1941 and the incidence was increased by certain population movements in 1945 and 1946 With the reorganization of antimalarial services in 1947 however the morbidity rate from malaria began to decrease [3]

Turkey

Mr P Bierstein subsequently proceeded to Turkey on the request of the Turkish Government, to advise on the latest methods of applying DDT Malaria control campaigns carried out in this country during the last 25 years principally consisting in the draining of marshes, have led to a marked decrease in the incidence of the disease The health authorities intend to continue the antimosquito campaigns by using DDT in the form of an emulsion or of a wettable powder so as to replace solutions in kerosene or crude oil

South-East Asia

Programmes are also being carried out in South East Asia, and demonstration teams are operating in various parts of India and Pakistan Dr G Gramiccia, malariologist, and M R Tavanello sanitary engineer are directing a demonstration team in East Pakistan Before proceeding to their field of operations they stopped in Teheran to

prepare a report on the malaria situation in Iran The Government of Iran is intending to devote to the antimalaria campaign a large part of the sum allocated in the budget for carrying out health programmes

Dr G Belios a Greek malariologist Chief of a WHO demonstration team was recently in Beirut where he met Dr J T Cottrell WHO representative with the United Nations Relief for Palestine Refugees Dr Belios subsequently proceeded to India where he organized a malaria control demonstration in the Terai region in the foothills of the Himalayas This district has been partially abandoned by its inhabitants as the high incidence of malaria has made agricultural work almost impossible An expert from the Food and Agriculture Organization participated in this programme

Palestine refugee camps

An intensive campaign against mosquitos by DDT spraying has recently been undertaken in the malarious regions of Lebanon Palestine Syria and Transjordan where the refugees from Palestine are located

This campaign is organized and directed jointly by the International Red Cross Committee the League of Red Cross Societies and the American Friends Service Committee It is partly financed by WHO and follows for the most part plans prepared by WHO malariologists who have recently carried out a tour of inspection in the refugee areas Antimalarial teams consisting of a foreman and five labourers under the direction of locally recruited sanitary inspectors are carrying out spraying operations in densely crowded refugee camps where the risks of infection are very great A special aircraft of the United Nations Relief for Palestine Refugees has helped to speed up the carrying out of the programme and already two tons of DDT have been transported by this means to Amman Beirut Gaza and Jerusalem DDT spraying will assist in the destruction of flies which act as vectors of intestinal diseases such as typhoid fever and dysentery both of which constitute a grave threat to health

WHO has contributed also to the financing of improved sanitation methods in the camps where such conditions are often unsatisfactory

Views on WHO

ilities of WHO for Mental Health

In an address to the 38th annual meeting the National Committee for Mental Hygiene New York City [1] Dr H S an the Editor of *Psychiatry* discusses part to be played by WHO in the ion of mental health

"The World Health Organization can ly be divorced from thought about he people who make up its reality Its entialities are not of a supernatural haracter however much the interferences with their realization may be referred to allegedly supernatural sanction Psychiatrists and their confrères in other fields of the study of living are the ones from whose experience skill, and collaborative genius the potentialities must derive and the strategy and tactics of their realization evolve

After raising a number of questions on the ability of psychiatrists to tackle public health problems Dr Sullivan expresses his conviction that the mental health potentialities of the World Health Organization are primarily a dependent function of the potentialities of psychiatry itself" He continues

I think that we may well realize that the initial realization of the mental and social health potentialities of the World Health Organization must be very limited but if the small beginnings are soundly conceived, their results will insure an increasing velocity of favorable change

"The initial steps must avoid any foreseeable evil consequences and this is by no means easy nor a task for the outlining of policy toward the achievement of which any one of us is particularly well prepared A mental health program that may be considered peculiarly advantageous for promotion in the United States may include many implicit assumptions that render it entirely impracticable for transplanting to some other sovereignty The promotion of world mental health cannot be founded on a single nation s ideology aspirations, and system of values It has to recognize great cultural differences reflected in surprisingly different obsta les and facilitations of personal growth

"I believe that the first realization of the potentialities for mental health and social welfare that inhere in the World Health Organization will come into being by conjoint effort of that agency and the United Nations Educational Scientific and Cultural Organization — UNESCO — in seeking a better understanding of community life around the world. Parallels and differences in the factors that promote and that interfere with harmonious and constructive interpersonal relations *in and between* such groups as the family the elementary school the secondary school and the local community need to be known if we are to sort out that which is widely if not universally conducive to harmonious and constructive human relationships in later life

The Immediate Task

Dr R B Fosdick President of the Rockefeller Foundation in his review of the Foundation s activities for 1947 stated, among other things

Our challenge in this generation is to discover the common interests, the terrain of possible collaboration the overlapping areas of curiosity and sympathy of aspiration and mutual advantage that bind the human race together regardless of ideologies or boundary lines. The search for these rallying points of unity the development of new techniques and areas of cooperative action where ideas and experience can be pooled and combined — this is the immediate task this comes first

M nt Hyg N Y 1948 32, 77

Rock f ller Found ion *Annual Report 1947* New Y rk, p 1

this is the foundation of the ultimate structure of a united society

The activities of the World Health Organization of the United Nations furnish a pertinent illustration for health is something that all men desire and there is no limited supply for which nations must compete Public health work carries no threat to anybody any where The world of disease and misery is not divided it is a common world In terms of human suffering the world is truly and tragically one world

The Physician as a Harbinger of World Peace

Dr J Salcedo President Manila Medical Society said before the Society at its inaugural meeting on 11 January 1949 [3]

The root of much of the social and political troubles here and elsewhere is poor health Men fight because they are hungry because their children are hungry They fight because they want to extricate themselves from the rut into which poverty disease and misery have pinned them down Give health to them and to their children and they will choose a life of peace

Health problems though seemingly of local concern always affect the rest of the world The Interim Commission which served prior to the full activation of the WHO for example gave top priority to the eradication of malaria a purely regional disease Why? Because malaria affects mostly agricultural coun tries and in this postwar era of food shortage the resulting loss in manpower from this disease is bound to be felt by the rest of the world

Thus we see that no individual or nation can isolate itself from the rest of the world By force of present circum stances what other people are and what other people do cannot but affect our lives The physician whose mission since time immemorial has been to cure diseases to alleviate suffering and to comfort man has in this era of ours one more sublime duty imposed upon him — to be the harbinger of world peace

International Sanitary Conventions

An editorial appearing recently in the *British Medical Journal* (1949 1 22) emphasizes the importance as well as the present shortcomings of the international sanitary conventions a problem which has been discussed in previous numbers of the *Chronicle* [4]

After outlining some of the anomalies of the present system of international sanitary control the editorial continues

It is obvious that one of the major tasks of WHO and one which is of considerable urgency is to draw up a new single convention to which all countries will freely subscribe There are at present 17 separate conventions or accords without counting the texts of the documents constituting WHO signed in New York in 1946 Such a unitary convention must not be cluttered with the dead wood of previous conventions the provisions of which were too often drafted not by experts but by persons who though they may have had medical qualifications had spent many years in government offices As a result the conventions may have been impeccable on the diplomatic level but were often sadly ineffective on the practical level The Assembly of WHO according to Article 19 of the Charter has authority to adopt conventions and accords relating to every question within the competence of the organization A majority of two-thirds of the Assembly is necessary for the adoption of these conventions and accords which will come into force so far as each member State is concerned as soon as the particular State has accepted it in confor mity with its constitutional rules It is sincerely to be hoped that there will be not only a change of form but of spirit and that governments will be less slow and less indifferent to accepting conven tions or regulations fully discussed and already adopted by the Assembly of WHO

[3] *J Philippine med Ass* 1949 25 31

[4] *Chron World Hlth Org* 1947 1 12 1949 3 1

Use of BCG in Europe

The January issue of the *Bulletin of the National Tuberculosis Association*, New York (1949 35 (1) contains an article by Dr H F Helmholz, Chief Paediatrician Mayo Clinic, Rochester Minn USA, on the use of BCG in the antituberculosis campaign now in progress in Europe with the material assistance of the United Nations International Children's Emergency Fund and the technical assistance of WHO[5] The various stages in the organization of the campaign and the results obtained since its inauguration on 1 July 1948 are explained

With the extensive use of BCG vaccine as outlined in this campaign writes Dr Helmholz, there should become available such a mass of evidence as to the effectiveness of BCG in checking active tuberculosis that no question will be raised in the future whether or not BCG vaccination is the primary line of defense in tuberculosis

Influenza

A leading article recently published in the *New England Journal of Medicine* (1949 240 313) deals with the international control of influenza with special reference to the WHO World Influenza Centre[6]

In this country [USA] the surgeons general of the Army Navy Air Forces and Public Health Service have developed a plan by which it is hoped to prevent a recurrence of a serious epidemic like that of 1918 This plan is part of an international program that was set up by the World Health Organization last year to study influenza and to aid physicians and health officers in the control of the disease An influenza information center to serve as headquarters in the United States has been established at the National Institutes of Health in Bethesda Maryland which would administer the program in this country and would serve as a liaison office between the International Influenza Centre and participating American laboratories

"Obviously the key to the success of this program is the cooperation of physicians in the early recognition and reporting of cases suspected of being influenza."

[5] *Chron. World Hlth Org.* 1948 2 56 1949 3 77 10

[6] See *Chron. World Hlth Org.* 1947 1 14 1948 2, 44 1949 3 11

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BIOLOGICAL STANDARDIZATION

IMMUNIZATION AGAINST CERTAIN DISEASES OF CHILDHOOD

INSECTICIDES AND DISINFECTATION

INTERNATIONAL QUARANTINE MEASURES

DISINFECTION OF AIRCRAFT

WORLD HEALTH ORGANIZATION
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Note — The *Chronicle of the World Health Organization* is published monthly in English, French, Russian, Spanish and Chinese. The *Chronicle* reports the activities of the Organization, without, however, claiming to be an authoritative record of its official views which are set out in the *Official Records of the World Health Organization*. All correspondence relating to it should be addressed to the World Health Organization, Palais des Nations, Geneva. Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom, more especially in the medical Press, are entirely at liberty to do so.

VOL. 3 No 7 JULY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

BIOLOGICAL STANDARDIZATION

THIRD SESSION OF THE EXPERT COMMITTEE

In the course of its third session held in London from 2 to 7 May 1949 [1] the Expert Committee on Biological Standardization noted the results of the research carried out by its members on the problems raised during the second session [2] In addition various new problems were examined and some important decisions taken [3]

Vaccines

Cholera vaccines In the preceding session the committee had entrusted one of its members with the task of preparing freeze-dried antigens with the object of producing in the rabbit agglutinating anti O sera for diagnostic purposes [4] For this purpose rabbits were inoculated with warmed cultures

The following took part in this session

Members

Professeur E. Grasset Directeur de l'Institut d'Hygiène Genève Switzerland
Dr A. A. Miles, Director Department of Biological Standards National Institute for Medical Research (Medical Research Council) London United Kingdom
Dr J. Dirk Director State Serum Institute Copenhagen Denmark
Major-General S. Sahib Singh Sokhey Director Haffkine Institute Bombay India
Dr W. Arg. Timmerman, Director Rijks Instituut voor de Volksgezondheid Utrecht, Netherlands (*Chairman*)
Professeur J. Trefouël, Directeur de l'Institut Pasteur Paris France
Dr M. V. Veldee Chief Biological Control Laboratory National Institutes of Health (US Public Health Service) Bethesda Md USA

Co-opted Members

Dr J. Bretey Chef de la Division de la Tuberculose Institut Pasteur Paris, France
Dr J. Chevé Directeur de l'Agence de l'Institut Pasteur Laroche-Beaulieu (Dordogne) France
Dr N. K. Jerne Acting Chief Department of Biological Standardization State Serum Institute Copenhagen Denmark

Secretary

Dr R. G. Hiscox Assistant Director-General, WHO

[1] The report of the second session was published in *Off. Rec. World Hlth Org.* 11, 8; see too *Chron. World Hlth Org.* 1948, 2, 116.

For decisions relative to laboratories see page 164

of the Inaba and Ogawa strains The antisera obtained were found to be specific for true cholera vibrios they did not agglutinate choleriform vibrios It was not possible, however, with these antisera to distinguish between the Inaba, Ogawa and El Tor types, which all have the same heat stable antigens

Recently a new element has been introduced in the elucidation of this question research has shown that the antigenic composition of the cholera vibrio is much more complex than had been thought In addition to the fundamental A antigen existing in all true cholera vibrios, 12 non specific antigens (B, , M) have been found to be present, distributed differently in the various types of vibrio [5] These observations which throw new light on the serology of cholera, resulted in the decision of the committee to defer the establishment of freeze dried antigens used in the production of diagnostic agglutinating sera until a detailed antigenic analysis of the various types of vibrio involved has been made

As a result of the recommendation made by the committee during the second session,[6] preparations of Ogawa and Inaba prophylactic vaccines have been established A critical comparison must now be made of the various techniques of assay on mice, through determining the activity of "unknown vaccines

Antipertussis vaccine Although certain vaccines are now available which have given satisfactory results in immunizing against whooping cough, it has not so far been possible to define precisely the factors determining the efficiency of antipertussis vaccine, nor to describe a standard method of preparation for an active vaccine In particular it is still unknown which antigens of *Haemophilus pertussis* play the principal role in immunity One of the obstacles to the establishment of potency standards for this vaccine by the usual methods arises from the varying interpretations of the turbidity of the suspensions in terms of bacterial content In order to reach agreement on the bacterial content of reference preparations, Dr Veldee agreed to place at the disposal of interested laboratories samples of the US National Institutes of Health turbidity standard, which is a suspension of particles of Pyrex glass in water Furthermore, in order to investigate the reasons for the variable results given by intracerebral injections into mice, Dr Veldee will make available to research workers the strains of *H pertussis* and of mice used in the laboratories of the National Institutes of Health The committee, therefore, decided to defer the establishment of a standard preparation of antipertussis vaccine until the following points have been cleared up

(*a*) The relation between the immunizing potency of the vaccine in laboratory animals and in man

[5] *Ch on World Hlth Org* 1949 3 6
Ch on World Hlth Org 1948 2 119

(*b*) the comparability of results obtained by independent workers in the evaluation of the various vaccines by comparison with a standard preparation

Smallpox vaccine The committee considered what investigations would be necessary for the definition of minimum requirements for smallpox vaccine It recommended that the seed vaccinia virus used in different countries for the preparation of smallpox vaccines be compared by injection into the rabbit with a freshly isolated strain of human variola virus The committee considered that India was a country presenting suitable conditions for such investigations and at the suggestion of Sir Sahib Singh Sokhey it recommended that WHO should ask the Government of India to make arrangements for the testing of seed virus

Toxoids

The establishment of international standards for diphtheria and tetanus toxoids presents a special problem in that the toxoids found on the market are of varying degrees of purity It is therefore essential to ensure that the unit of diphtheria and tetanus toxoids representing a particular weight of the standard preparation should permit an evaluation of the activity of all the existing toxoids

A further difficulty in the assay of a toxoid results from the time factor for animals immunized at the same time the maximum immunity is reached in varying periods the result of the assay will therefore depend on the time at which the observation is made

In order to define the problem a little more closely the committee considered that preparations of purified diphtheria and tetanus toxoids intended to serve as international standard preparations should be compared with the plain toxoids currently employed in different countries for human immunization In this way it should be possible to determine what quantity of the proposed standard preparation might conveniently be regarded as corresponding to unit immunizing potency

Antitoxins

Streptococcus antitoxin The Department of Biological Standards of the National Institute for Medical Research London has supplied a preparation of streptococcus antitoxin which appears suitable for an international standard An estimation of the potency of this preparation in terms of the US National Institutes of Health streptococcus antitoxin is to be made by laboratories in four countries

Tetanus antitoxin A question which has been the subject of long discussions and difficult negotiations in recent years was settled during

this session The international unit for tetanus antitoxin will henceforth be the same as the USA unit The weight of the international standard preparation at present corresponding to unit potency will therefore be doubled This change, which has been considered desirable for a long time by numerous countries should be announced as soon as possible and should take effect as from 1 July 1950 at the latest

Substances used in Serodiagnosis

Salmonella infections Agglutination tests for the serodiagnosis of enteric infections caused by *Salmonella* will undoubtedly continue to be used all over the world for a long time to come It is as a result of such tests that epidemiological inquiries can be carried out successfully, latent infections discovered and carriers traced

The standardization of agglutinating reactions is therefore just as important now as it was in 1934, when the agglutination test using Vi antigen for the detection of chronic typhoid carriers became general and the establishment of standard antisera and suspensions for Vi antigen agglutination was found to be indispensable At present the preparation of standard antisera for agglutination tests with the H and O antigens would represent a further step towards the standardization of Widal's reaction The committee accordingly accepted the proposal of Dr A Felix of the National Institute for Medical Research London that specific antisera should be prepared for the following antigens

Salmonella typhi (H)
Salmonella typhi (O)
Salmonella typhi (Vi)
Salmonella paratyphi A (H)
Salmonella paratyphi A (O)
Salmonella paratyphi B (H)
Salmonella paratyphi B (O)
Salmonella paratyphi non specific (H)

Rickettsial infections In spite of the progress represented by the successful culture of *Rickettsia* on the chick embryo diagnosis of these infections by the agglutination of *Rickettsia* suspensions is too delicate a test for everyday use in all laboratories Serodiagnosis by agglutination with the O antigen of *Proteus X* remains the simplest test The committee accepted the proposal of Dr Felix to prepare antisera for the specification of the X strains of *Proteus vulgaris* for specific agglutination tests in the serodiagnosis of rickettsial infections Antisera for the following antigens will be made *Proteus vulgaris* OX19 OXK and OX2 The committee recommended that these antisera be examined in laboratories in six countries for their suitability as international standard preparations

PPD

Different preparations of PPD produce markedly different reactions in hypersensitive persons and animals Moreover PPD and similar substances prepared in different ways contain variable proportions of active fractions having different molecular weights These variations represent a serious obstacle to establishing a reference preparation The committee therefore recommended that before taking any decision on this question a comparative biological and physicochemical examination of certain types of purified proteins be carried out in five laboratories

Production and Distribution of BCG

At the request of UNICEF Dr Timmerman Sir Sahib Singh Sokhey and Dr Gautier have made a study of the conditions under which BCG intended for use in vaccination campaigns is prepared at the institutes in Paris Copenhagen Algiers and Madras The committee examined the conclusions of these experts and defined the conditions which should be satisfied by laboratories engaged in the preparation of BCG [7] The Institut Pasteur Paris has declared its willingness to act as a world centre for the preparation and distribution of freeze-dried BCG cultures The distribution will be made monthly both to the laboratories producing BCG for the UNICEF vaccination campaigns and to other interested laboratories on the recommendation of the national control centres for the distribution of international standard preparations

Anti pernicious-Anaemia Factor

A method for measuring the anti pernicious anaemia potency of extracts of liver and other animal tissues has now become an urgent necessity As a result of the recent isolation of vitamin B_{12}, which is one of the anti pernicious anaemia factors in liver extract a substance apparently suitable for this evaluation is now available The microbiological method using a culture of *Lactobacillus lactis* Dorner which requires vitamin B_{12} for its growth seems to be the best comparative assay

The very high potency of crystalline vitamin B_{12} as well as the small amount available makes distribution difficult (A quantity of the order of 5 mg must be divided up into 1 000 ampoules) To avoid any possibility of waste the substance should be introduced into the ampoule in a liquid form and then freeze dried with some bulking material

As it is only recently that vitamin B_{12} has been discovered enough information is not at present available on the stability of this substance

[7] These conditions will be published as an annex to the report of the Expert Committee on Biological Standardization in *Off. Rec. World Hlth Org.* 23.

this session The international unit for tetanus antitoxin will henceforth be the same as the USA unit The weight of the international standard preparation at present corresponding to unit potency will *therefore be* doubled This change, which has been considered desirable for a long time by numerous countries, should be announced *as soon as possible and should* take effect as from 1 July 1950 at the latest

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Salmonella paratyphi A (O)
Salmonella paratyphi B (H)
Salmonella paratyphi B (O)
Salmonella paratyphi, non specific (H)

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Hormones Standard preparations of oestrone and oestradiol monobenzoate are of no further value as biological standards and will cease to be issued as from 1 January 1951 In view of the present interest in thyrotrophin and corticotrophin, the committee considered it desirable to seek the opinion of specialized workers as to the advisability of establishing standards for these hormones

Antibiotics A second standard sample of penicillin G (II) will be prepared The streptomycin preparation held since April 1948 by the Department of Biological Standards of the National Institute for Medical Research London will be adopted as the international standard A reference preparation of dihydrostreptomycin will be established

SUB-COMMITTEE ON FAT SOLUBLE VITAMINS

The knowledge acquired during the last few years of the chemistry of fat soluble vitamins has made a revision of present standards necessary In accordance with the suggestion made in 1947 by the Expert Committee on Biological Standardization a specialist Sub-Committee on Fat Soluble Vitamins has been set up This sub-committee met in London from 26 to 29 April 1949 [1] and formulated recommendations on the standardization of vitamins D and A which have been adopted by the committee

Vitamin D The standard for vitamin D adopted in 1931 by the Permanent Commission on Biological Standardization of the Health Organization of the League of Nations consisted of a solution of irradiated ergosterol containing a certain proportion of vitamin D_2 Crystalline vitamin

[1] The following took part in the session

Members

Professeur A Chevallier Professeur de Physique biologique à l'Université de Strasbourg, France

Miss K. H. Coward, D.Sc. Head, Nutrition Department, School of Pharmacy University of London, United Kingdom

Professor N B Guerrant, Professor of Biochemistry Pennsylvania State College State College Pa., USA

Professor B C. P Jansen, Professor of Physiological Chemistry University of Amsterdam, Netherlands

Sir Edward Mellanby Secretary Medical Research Council, London, United Kingdom (*Chairman*)

Dr E. M. Nelson, Chief Division of Vitamins Food and Drug Administration, Washington D C USA

Dr R. Nicolaysen, Professor of Nutrition Director Institute for Nutritional Research, University of Oslo Norway

Dr F Verzár Professeur de Physiologie à l'Université de Bâle Switzerland (*Representing FAO*)

Co-opted members

Miss E. M Hume External Scientific Staff Medical Research Council Lister Institute for Preventive Medicine London, United Kingdom (*Joint Secretary*)

J O Irwin, D.Sc. Statistical Research Unit, Medical Research Council London School of Hygiene and Tropical Medicine London, United Kingdom

Professor R A. Morton, Professor of Biochemistry University of Liverpool United Kingdom

Observers

N Y Gridgeman, Biochemist, Research Department, Lever Bros and Unilever Ltd, Port Sunlight, United Kingdom

Dr A A. Miles Director Department of Biological Standards, National Institute for Medical Research (Medical Research Council), London, United Kingdom

Dr A. Neuberger Department of Biochemistry National Institute for Medical Research (Medical Research Council), London, United Kingdom

Secretariat

Dr R. Gautier Assistant Director-General, WHO

The Department of Biological Standards of the National Institute for Medical Research London, has been authorized to procure a sufficient quantity of the pure vitamin to enable a standard to be established and to consult with interested workers regarding the unit of activity which they would like to see adopted

Blood Groups

A B O groups The findings of eight of the eleven investigators who examined anti A and anti B sera proposed as standards for the determination of A and B groups[8] show that these sera are of suitable quality and potency Their potency will be exactly defined as soon as all the results of the examination are known

Rh groups The committee felt that at present it was not expedient to establish international standard preparations of the various anti Rh sera, nor to make any recommendations on the notation of the Rh groups On the other hand, it was considered desirable to find a generally acceptable definition of the terms " Rh negative donor and 'Rh negative recipient' A certain amount of confusion exists on this point, arising from the fact that specialists do not always apply these terms to individuals whose blood contains the same Rh antibodies The committee therefore recommended after discussion, that the term *Rh negative donors* should be applied to persons whose erythrocytes are not agglutinated by the three following sera

Wiener notation	*Fisher Race notation*
anti Rh_o	anti D
anti Rh	anti C
anti Rh	anti E

while individuals whose erythrocytes are not agglutinated by an anti Rh_o (Wiener) or anti D (Fisher Race) serum should be considered as *Rh negative recipients* An Rh negative recipient is not necessarily an Rh negative donor

Other Questions

Since stocks of certain international standards are almost exhausted it will be necessary to take steps for their replacement

Digitalis This is particularly so in the case of digitalis for which a third international standard has been prepared using batches from three countries Its activity will be defined in accordance with the combined results of assays to be carried out in 17 laboratories situated in nine different countries

[8] *Chron Wo ld Hlth O g* 1947 1 110

by the Executive Board during the consideration at its third session of the report of the Expert Committee on Maternal and Child Health[2] — and the subjects which should be included in the agenda for such a conference

The experts reviewed the present possibilities of immunization against the communicable diseases of childhood and some of the observations made during this critical examination are summarized below[3]

The experts decided to exclude from their discussions those communicable diseases (smallpox tuberculosis cholera and yellow fever) which are already receiving the attention of WHO so as to focus their attention on diphtheria whooping cough scarlet fever mumps, measles tetanus poliomyelitis and typhoid and paratyphoid fevers During the discussion on these diseases they summarized present knowledge and indicated the lines along which it would be necessary perhaps even imperative to undertake research

Technical Conference on Immunization

A technical conference it was agreed which might encourage and facilitate the adoption of better techniques by laboratories still using obsolete methods would have many advantages The exchange of information on the different methods of production and preparation of vaccines against diphtheria and whooping cough would throw light on the reasons for the divergent results obtained while the conference might also guide and stimulate research and awaken the interest of health authorities the medical profession and the general public in immunization programmes The experts were therefore in favour of holding such a conference but believed that to be profitable it should be limited to a small number of participants so that discussions could be of a rapid and informal nature and restricted to the study of the methods of production of vaccines against diphtheria and whooping cough

Childhood Diseases and Immunization Possibilities

Diphtheria In temperate countries where diphtheria is prevalent, the experts considered that all children should be immunized against the disease In tropical countries infection by the diphtheria bacillus occurs generally without a manifestation of clinical symptoms Alum precipitated toxoid (APT) is the most suitable preparation for immunizing children and immunity is acquired after two injections On the other hand fluid toxoid or toxoid antitoxin floccules (TAF) are preferable for immunizing adolescents and adults

[2] *Off. Rec. World Hlth Org.*, 1946, 13. *Chron. World Hlth Org.*, 1949, 3, 48.

[3] The report on this meeting will be published in full in *Off. Rec. World Hlth Org.*, 23.

D_3 (irradiated 7 dehydrocholesterol) recently recognized as being identica with the natural vitamin, has now been prepared in sufficient quantity for it to be adopted as an international standard The crystalline preparation of vitamin D_3 will thus be adopted henceforth as the international standard for vitamin D

The international unit of activity of vitamin D will be equivalent to the activity of 0 025 μg of the standard preparation of crystalline vitamin D_3 The solution of irradiated ergosterol will be kept as a reference preparation until the stability of vitamin D_3 has been verified

Vitamin A In 1934 the second Conference on Vitamin Standardization adopted β carotene, in the absence of a more suitable preparation, as the international standard for vitamin A During recent years several esters of vitamin A have been prepared, of which the acetate seems particularly suitable for use as a standard However β carotene will be retained as the standard of provitamin A

The properties which would be possessed by crystalline vitamin A acetate were defined, as well as those of the oil in which it should be dissolved in order to constitute the standard preparation The unit of activity of vitamin A was defined as being that of 0 344 μg of the standard preparation of crystalline vitamin A acetate equivalent to 0 3 μg of vitamin A alcohol [10]

[1] The report of the sub-committee giving details of the physical chemical and physicochemical properties of the standard preparations of vitamins D and A, as well as of provitamin A, will be published in *Off Rec World Hlth Org* 23

IMMUNIZATION AGAINST COMMUNICABLE DISEASES OF CHILDHOOD

Consultation of Experts

At the invitation of the Director General of WHO, a group of experts [1] met at Geneva from 25 to 28 May 1949 to discuss, in particular, the desirability of calling a technical conference to examine procedures for immunization against communicable diseases of childhood—as recommended

[1] The following were present at this meeting

Expert Consultants

Dr J A Bell Senior Surgeon Laboratory of Infectious Diseases National Institutes of Health Bethesda, Md USA

Dr K Boylén Consultant State Serum Institute Chief Physician, School Health Service Copenhagen, Denmark

Professor J A de Loureiro Professor of Hygiene and Public Health University of Lisbon Portugal

Professor G S Wilson Director Public Health Laboratory Service Medical Research Council London, United Kingdom

Secretaries

Dr Y M Biraud Director Division of Epidemiology WHO

Dr E A Leppo Maternal and Child Health Section, WHO

Dr R Gautier Assistant Director General WHO attended several meetings

by the Executive Board during the consideration at its third session of the report of the Expert Committee on Maternal and Child Health [2]— and the subjects which should be included in the agenda for such a conference

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[2] *Off Rec World Hlth Org* 19 46 *Chron. World Hlth Org* 1949 3 45

[3] The report on this meeting will be published in full in *Off Rec World Hlth Org* 23

In the experts' opinion, primary immunization should be effected between six and twelve months of age by means of 2 APT injections made at a one month interval One or two reinforcing doses may be given during the first five years followed by others at intervals of five years up to the age of 15 The experts thought that it was useless to employ the Schick reaction as a routine test, since a negative reaction is no absolute guarantee of protection against infection and vaccination can serve only to strengthen the child's immunity to the disease

It was recommended that research should be continued with a view to finding an antidiphtheria vaccine which would not give rise to local or general reactions The experts pointed out that the new preparation of purified toxoid aluminium phosphate precipitated (PTAP) appeared to give as good, if not better, results than those obtained with APT If the large scale trials which are now being carried out confirm the results of preliminary investigations, it is possible that this new preparation might be recommended for general use in place of APT

Whooping cough The experts considered that whooping cough which has a worldwide prevalence is one of the most important diseases of early childhood as regards both morbidity and mortality even though its mortality is now decreasing in a number of countries If a satisfactory vaccine were available it would therefore be highly desirable to immunize infants and pre school children

After considering a large number of both laboratory experiments and field trials the experts agreed that certain of the vaccines used had given a high degree of protection, while others had had little or no effect They considered, however that existing knowledge concerning whooping-cough vaccines was still insufficient to make it possible to prepare vaccines of uniform protective potency and sure efficacy [4] It would appear premature, therefore, to recommend a worldwide routine vaccination of all children

Research on whooping cough should attempt to secure an explanation of the divergent results obtained with various vaccines or even with different batches of the same vaccine To achieve this the following points should be studied choice of strains techniques for culturing sampling and sterilizing vaccine , methods of preserving the vaccine before use , and standardization of the vaccine by physical and biological methods In addition an urgent need existed for a reliable laboratory test for estimating the protective potency of the vaccine for human beings

Scarlet fever In most countries scarlet fever has become so mild that large scale vaccination is not justified particularly since serious post vaccinal complications have occasionally been observed The experts thought that vaccination should be considered only for communities where

See page 142.

the disease was still highly prevalent or where the risks of infection were particularly high.

Further work should aim at developing a test for detecting individual susceptibility at finding a more satisfactory immunizing agent than the toxin preparations now in use and finally at investigating the relation between the various streptococcal infections

Mumps The experts considered that vaccines against mumps were still in the experimental stage They advised against the use of a vaccine which would not ensure life long immunity as mere postponement of the disease until after puberty would increase the risk of complications

Measles No procedure for active immunization against this disease has yet been discovered The risk of postponing the disease by inducing an immunity of limited duration exists in measles as in mumps and for the same reasons a vaccine which does not ensure life long immunity should not be used

On the other hand the following agents may be used for securing passive immunization gamma globulin from the serum of human beings who have had measles serum from convalescents or pooled adult serum These substances may prevent or attenuate the disease for a limited period but this passive immunization should be limited to children under three years of age or to older children who are in a poor state of health and exposed to infection with measles or who are in hospitals or other institu tions where it may be impossible to prevent the occurrence or spread of the disease

The experts stressed that it was inadvisable to prevent measles in healthy children over three years of age by the above procedures since a passive immunization is of a temporary duration and only postpones the risk of infection Moreover the danger of human serum hepatitis which may accompany the use of any of these products must be taken into considera tion

Research is necessary on the practical utilization of ultra violet rays for the destruction of the icterogenic virus in the immunizing sera and towards developing a vaccine giving life long immunity

Tetanus Tetanus is of worldwide distribution particularly in areas where wounds are likely to be contaminated with manured soil and newborn babies to be infected following defective handling The experts therefore agreed that the use of the very effective active and passive immunizing agents now available should be recommended

Passive immunization by antitetanus serum generally ensures protection lasting for about three weeks But the serum has certain disadvantages and in inducing horse serum sensitiveness may later cause serious anaphy lactic reactions if further doses of any horse serum are used

Vaccination with tetanus toxoid is indicated when it is a question of protecting certain groups—agricultural workers workmen, army personnel—or even the whole population It is carried out by means of two or three spaced injections followed by reinforcing doses in the case of wounds, and experience has shown that the immunity thus obtained lasts from five to six years After this period a fresh injection should be made.

A national programme of antitetanus immunization should also include vaccination of infants since tetanus can be contracted at any age Alum precipitated toxoid which is more active than fluid toxoid is advisable for use for vaccinating children

Research is necessary into the duration of immunity given by the initial vaccination, so as to determine at what intervals reinforcing doses are advisable In areas where tetanus of newborn babies by infection of the umbilical cord is frequent it would be advisable to study the possible efficacy of the vaccination of pregnant women

Poliomyelitis As no method of active or passive immunization against poliomyelitis has passed the experimental stage, no practical recommendations could be made at present

Typhoid and paratyphoid fevers It was difficult to make any general recommendations for these diseases as their prevalence varied from one country to another In countries where typhoid fever is endemic, immunization could be included in the general health programme

Combined Immunizations

The experts were in agreement that the combination of several antigens in mixed vaccines could not only decrease the number of injections required for immunization against different diseases but could also produce immunity titres equal to or greater than those which could be obtained by separate inoculation of each antigen It has been shown for example, that whooping cough vaccine, when mixed with diphtheria toxoid increased the antigenic potency of the latter

The immunizing agents most frequently used in combination are

(*a*) typhoid paratyphoid and cholera vaccine ,
(*b*) diphtheria and tetanus toxoids (fluid or alum precipitated) ,
(*c*) diphtheria toxoid and whooping-cough vaccine
(*d*) diphtheria and tetanus toxoids and whooping-cough vaccine ,
(*e*) smallpox and yellow fever vaccines

Immunization Programmes

The experts made the following suggestions for immunization programmes for the entire population

Smallpox Primary vaccination between 1 and 6 months of age re vaccinations on entering school and on leaving school (or at 10 years of

age) In countries where the disease is endemic and when the risk of infection is particularly great revaccination at frequent intervals is recommended

Smallpox and diphtheria Smallpox vaccination according to the scheme indicated above Primary immunization against diphtheria between 6 and 12 months of age with reinforcing doses within 5 years then every 5 years until the age of 15

Smallpox diphtheria and whooping cough Smallpox vaccination according to the scheme indicated above Combined immunization against diphtheria and whooping cough 2 or 3 doses at one month interval from the second or third month if whooping cough is prevalent in the community, otherwise primary immunization may be delayed until the sixth month First reinforcing dose of the combined vaccine should be given about 1 year after the primary immunization the second by the age of 5 or on school entry Further reinforcing doses at 10 and 15 years need contain only diphtheria toxoid

Smallpox diphtheria whooping cough and tetanus Smallpox vaccination according to the scheme indicated above Combined immunization against diphtheria whooping cough and tetanus as indicated with the combined diphtheria and whooping-cough vaccine except that the reinforcing doses at ages of 10 and 15 should include only diphtheria and tetanus toxoid

Smallpox diphtheria and tetanus The schedule is the same as for combined smallpox and diphtheria vaccines using the diphtheria and tetanus toxoids instead of the diphtheria toxoid alone In communities which are difficult of access to health personnel smallpox vaccination and diphtheria immunization may be carried out simultaneously (one on each arm)

INSECTICIDES AND DISINSECTIZATION

First Session of the Expert Committee on Insecticides

The Expert Committee on Insecticides held its first session at Cagliari (Sardinia) from 10 to 15 May 1949 This committee whose terms of reference cover a very wide field including the chemistry and bio-assay of insecticides the physical chemistry of different preparations, insect physiology the study of materials for use as insecticides and the toxicity of insecticides consists of a nucleus of three experts in association with

Vaccination with tetanus toxoid is indicated when it is a question of protecting certain groups—agricultural workers, workmen, army personnel—or even the whole population It is carried out by means of two or three spaced injections followed by reinforcing doses in the case of wounds and experience has shown that the immunity thus obtained lasts from five to six years After this period a fresh injection should be made

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(*d*) diphtheria and tetanus toxoids and whooping cough vaccine ,
(*e*) smallpox and yellow fever vaccines

Immunization Programmes

The experts made the following suggestions for immunization programmes for the entire population

Smallpox Primary vaccination between 1 and 6 months of age , revaccinations on entering school and on leaving school (or at 10 years of

Other insecticides The present state of physical and chemical research with respect to insecticides other than DDT does not yet justify the drafting of specifications for these substances However it is possible to make use of biological assay—as in the case of the gamma isomer of benzene hexachloride—using a sample of the pure substance as a standard

The pyrethrin content of pyrethrum flowers is at present being determined in various laboratories it should soon be possible therefore to establish specifications for insecticides based on pyrethrum The committee recommended that the WHO Secretariat collect all available information on the chemistry of BHC chlordane toxaphene piperonyl butoxide parathion pyrethrum and all other insecticides used against disease vectors

Insecticidal preparations In view of the number and diversity of insecticidal preparations it is impossible to fix specifications for all of them The committee therefore decided that the simplest plan was to indicate the essential points to which purchasers should pay attention the constituents of the preparation the degree of purity the flash point, corrosive properties etc [*]

Specifications for Sprayers

The committee restricted itself to laying down the general requirements which should be satisfied by the various types of both compression and hand sprayers since it was considered that it would hardly be practicable to market a single model suitable for use in all regions and complying with all requirements The draft specifications given refer to the materials utilized capacity and weight as well as to certain points relating to the construction of the different component parts of the spray (cylinder pump filters distributor, etc) Several technical improvements have been recommended

Harmlessness of DDT to Man

The committee took the opportunity to contradict certain rumours which had been circulating concerning the toxicity of DDT to man and mammals It was decided to include the examination of reports on experimental work which has been carried out on this subject in the agenda for the next session

Disinsectization in Relation to Quarantine Measures

Ships The committee adopted in principle the regulations drawn up by ERLAAS (Ente Regionale per la Lotta Anti Anofelica in Sardegna a regional organization responsible for controlling anophelines in Sardinia)

[*] Technical details on this subject, as well as on the other points mentioned in this article, are given in the complete report of the committee which will be published in *Off. Rec. World Hlth Org.* 23

a panel of specialist members co opted according to the subjects selected for each particular question on the agenda [1]

Cagliari was chosen for the site of the meeting so that the members of the committee could see at first hand the effective results of the campaign carried out against anophelines in the island as well as of the measures taken to prevent the reintroduction of these insects by sea or air

During this session, the committee was required to give technical advice to the Expert Committee on Malaria on international standards to be adopted for the insecticides employed for malaria control and on the requisite specifications for spraying equipment The committee had also to suggest suitable methods for the disinsectization of ships and aircraft, in order that appropriate recommendations could be inserted in the WHO Sanitary Regulations to propose measures to be undertaken to prevent the introduction of anophelines into non infested areas and to study the role of insecticides in the control of flies

Specifications for Insecticides

Commercial DDT The specifications established in the USA and in the United Kingdom for commercial DDT have been utilized as a basis for the drawing up of detailed specifications governing its stability and its contents of chlorine, ash, para para isomer, etc

Nomenclature The committee recommended that the following names be used, in preference to trade names or synonyms, in order to avoid confusion

Name recommended	*Trade name and synonyms*
DDT (dichloro diphenyl trichlorethane)	Gesarol, Neocid, ENB A, SBLY
BHC (benzene hexachloride)	Gammexane 666
Chlordane	Velsicol 1068 Octa Klor
Parathion	Thiophos
Toxaphene	Chlorinated camphene 3956, Hercules 3956

[1] The following took part in this session

Mr M Aziz Bey Chief Health Inspector Med cal Department N cosia Cyprus
Médecin Lieutenant-Colonel J Duguet Médecin-Chef du Centre d Examen méd al du Personnel navigant de l Aviation Paris France member of the committee nucleus (*Chairma*)
Dr R A F Galley Secretary Interdepartmental Insect cides Committee London United Kingdom member of the committee nucleus (*Vice Chairman*)
Mr F W Knipe Assistant Director Ente Regionale per la Lotta Anti Anofelica in Sardegna (ERLAAS)
Dr J A Logan Superintendent Ente Regionale per la Lotta Anti Anofelica in Sardegna (ERLAAS)

Secretariat

Dr Y M Biraud Director Divis on of Ep demiology WHO
Dr E J Pampana Chief Malaria Section, WHO
Mr J W Wright Sanitary Eng neer Malaria Section WHO

The third member of the comm ttee nucleus Mr S W S mmons Senior Scientist Comm nicable Disease Center Savannah Georgia, USA, as well as Dr Jayawickrama Ceylon who had been invited as a co-opted member was unable to attend the meet ngs

Role of Insecticides in the Control of Flies

The committee noted that in certain countries the control of anophelines by spraying with residual action insecticides has in the absence of any sanitary methods contributed to the disappearance of flies whose importance in the propagation of disease is becoming more and more widely recognized

However to make the best use of the new insecticides it is essential in fly control to ascertain certain useful biological data such as their habits and habitat As it has been recorded that strains of houseflies which are resistant to DDT have evolved after DDT treatment of dwelling places it is preferable to use other insecticides such as chlordane or BHC. Research should be carried out on the possibility of prolonging the residual action of these insecticides

Availability of Insecticides and Materials

The committee noted with satisfaction the resolution adopted by the Economic and Social Council requesting the Secretary General of the United Nations to prepare a report on the production distribution and availability of insecticides for malaria control[5] It is emphasized that in several countries which do not produce insecticides particularly in underdeveloped countries the customs duties imposed on insecticides and on materials necessary for disinsectization constitute a serious obstacle to insect control consequently it is recommended[6] that the Economic and Social Council study the question of a customs franchise for such products

Exchange of Information and Literature

In view of the rapid progress now being made with regard to insecticides and their methods of application the committee recommended that information on these subjects should without delay be made available by the WHO Secretariat, to health administrations specialized services and individual experts

[5] This question will be considered by the Economic and Social Council during its session in July

[6] *Chron. World Hlth Org.* 1948 2, 149

which are intended to prevent the reintroduction of anophelines into the island These regulations provide for the anti mosquito treatment of all ships which come from ports situated between latitudes 55° N and 40° S and which are not in *possession of a certificate*, not more than two months old, of disinsectization by insecticides with a residual action The disinsectization procedures recommended include the use of aerosol bombs containing pyrethrum, and sprays of insecticides with a residual action

The committee had the opportunity of *attending disinsectization* operations carried out on board a cargo vessel and of judging the efficacy of the methods recommended The disinsectization of a vessel of 2,000 tons takes one and a half hours

Aircraft The committee examined among others, the report made by Dr Duguet on the disinsectization of aircraft [3] in which he recommends that methods of disinsectization be adapted to the various types of aircraft in use, i e , standard aircraft aircraft with pressurized cabins [4] and *military* aircraft, and emphasizes the necessity for these measures being strictly enforced on taking off and landing and, in certain cases even during flight The committee also drew up recommendations with regard to the different insecticidal preparations containing pyrethrins and DDT which should be applied, in the form of aerosols or emulsions, to the interior and the exterior of the aeroplane

Measures intended to prevent the introduction of anophelines into non infested areas The committee was of the opinion that disinsectization of ships and aircraft, when carried out efficiently constituted a real safe guard against the introduction of anophelines The same methods should also be applied to road traffic whenever necessary However, the application of disinsectization measures by quarantine services at ports and frontiers can never ensure complete protection , it is essential that systematic cam paigns against anophelines should be instituted in areas where malaria is not endemic and should be continued in those areas which have been freed from the pests, so that immediate steps may be taken in the event of the accidental introduction or reintroduction of the insects In order that these measures may be effectively carried out, the different disin sectization services should all be responsible to one central authority

In regions which have been freed from anophelines, continuance of the use of sprays, containing insecticides with a residual action, for con trolling domestic insects is an effective means of destroying mosquitos which may be accidentally introduced , on the other hand, it is necessary to strengthen regulations concerning the notification of cases of malaria and the confirmation of the diagnosis in the laboratory

This report will be published in *Bull World Hlth Org* 1949 2 155 see also page 160

A pressurized cabin is an air tight cabin kept under constant pressure

the epidemiology of diseases transmitted by such vectors species of insects found in aircraft necessity for carrying out disinsectization types of insecticides to be used for the different parts of aircraft methods of application of insecticides evaluation of the efficacy of disinsectization

In his report the complete text of which is to be published in the *Bulletin of the World Health Organization*[1] Dr Duguet reaches the following conclusions

1 Because of the evident danger constituted by the possible air transport of insect vectors of disease it is advisable to obtain strict adherence to the stipulations of Article 54 of the International Sanitary Convention for Aerial Navigation of 1933 1944 which prescribes the disinsectization on departure of all aircraft leaving an infected area

2 The disinsectization of aircraft when carried out by the proper means appears to constitute an effective prophylactic measure against such a danger It cannot however by itself provide an absolute health safeguard

3 It is therefore imperative whenever environmental and climatic conditions are favourable to maintain and develop control measures against mosquitos in the vicinity of airports open to international air traffic in order to eradicate locally all agents which are vectors of malaria yellow fever or other diseases spread by insects or at least to limit the likelihood of mosquitos penetrating into aircraft landing or parking on such airfields

4 Moreover in accordance with the recommendations of the Expert Committee on Malaria of the World Health Organization and independently of disinsectization procedures for aircraft it appears useful as a supplementary measure to take steps towards permanent eradication of *Anopheles* from aerodromes and sea bases in order that mosquitos which might possibly be introduced by aircraft into a territory normally free or which has been freed from malaria cannot find conditions favourable to their development

5 Although technical means which are at present available for the disinsectization of aircraft offer appreciable health safeguards and can be carried out with reasonable ease it would be useful if with the object of improving the methods of dispersing insecticides and of rendering a larger number of insect species susceptible to their action further research could be undertaken on the following lines

(*a*) search for effective aerosols against the principal insect species usually encountered in aircraft and especially against agricultural pests

(*b*) determination of the duration of the residual insecticidal action of surface DDT applications in commercial aircraft in present use

[1] *Bull. World Hlth Org.* 1949 2 155

covered by international sanitary conventions Most of them also include all communicable diseases except tuberculosis and venereal diseases, some countries even require to be informed of the existence of suspected cases With regard to the transmission by radio of the contents of the ship s bill of health 20 countries state that it is unnecessary, 7 do not specially request it 15 still require it, and 1 expresses no opinion on the subject

Transmission of the message In 23 countries the message must be sent directly to the port health authority 18 countries agree to its being sent through the intermediary of shipping agents in 2 countries this intermediary is allowed at certain ports but is not authorized at others

Replies received to the question whether the transmission of the message was optional or compulsory for this or that category of ship varied widely since health conditions in each State naturally differ considerably

Charges Where charges are made they are usually equivalent to those for ordinary telegrams The actual amount is generally fixed at so much per word payable either in local currency, in pounds sterling or in gold Arrangements can sometimes be made in this respect

Finally, 24 nations include in their Maritime Sanitary Regulations special provisions relating to the granting of radio pratique

Future Prospects

It is hoped that national health administrations will benefit by consulting this preliminary list and that port health services, as well as shipping companies and their agents, will make use of it

It is hoped that it will induce a greater number of administrations to use and to adopt officially this system Here as elsewhere, the practical value of a form planned on an international basis lies in its universal use It may also be hoped that in the months to come the system of international quarantine messages by wireless will be adopted by still more countries, which would lead to the compilation of a second and more comprehensive list of ports where ships arriving from abroad could be granted free pratique more easily and quickly

DISINSECTIZATION OF AIRCRAFT

Disinsectization of aircraft was one of the subjects on the agenda of the recent session of the Expert Committee on Insecticides [1] Dr J Duguet, Médecin Lieutenant Colonel du Service de Santé de l'Air (France) a member of the committee, had prepared a report reviewing the various aspects of the question accidental transport of insects in relation to

[1] See page 153

strong support. Massermann in particular by the action of external influences, has succeeded in inducing and fixing in animals certain types of nervous and psychological disorders which are amenable to the same treatments as human illnesses In the opinion of this author symptoms of mental disorders should be considered as the reaction of the psyche to conditions and events in the external world and not as a pathological state of the psyche itself The causes of the disease should be sought in disturbances of the emotional life the relation of which to the neurovegetative hormonal system has been demonstrated by several workers This would make it possible to explain the fa t that the same psychological symptoms appear in ailments which, according to previous systems of classification, are different from one another

According to this dynamic conception no rigorous distinction can be established between functional disturbances neuroses and psychoses these disorders do not differ in nature but only in degree The adaptation of the individual to the external world becomes the sole criterion by which the disease and its gravity can be evaluated Man is not an isolated being but an individual living in a community and consequently it is advisable to consider his reactions in relation to the social group as a whole For this very reason dynamic psychiatry is no longer a science concerned only with the individual, but is becoming a group science which must be practised in close connexion with mental hygiene This trend is particularly evident in therapeutics Psychotherapy in fact, is tending more and more to abandon individual analysis in favour of group analysis.

These new ideas have also had an effect on the organization of clinics and centres for the treatment of mental disorders In the second part of his article Dr Pakesch gives a general account of the application of this new concept of psychiatry on a social scale in the United Kingdom and of the part which the health authorities of the country have taken in carrying out mental health programmes

Mental hospitals intended for the treatment of neuroses and psychoses in their initial stages are planned so that the patient is in pleasant surroundings while undergoing the treatment which should enable him to adapt himself to the demands of everyday life Nurses in psychotherapeutic centres should hold a school leaving certificate and should have completed a six year course of study In general the staff at these centres comprises a state registered nurse and four assistant nurses to every twelve patients and, in addition a psychologist responsible for carrying out psychological tests Hospitals with at least 36 beds also have a matron, with responsibilities of a medical nature and a deputy matron to whom the administrative duties are assigned

The assistance given to patients after recovery plays a considerable part in the success of the programme as a whole To a great extent this assistance is rendered by social workers who are required to have a university education and special training in medicine and psychology The social workers form part of the health-service administration which makes their services available to clinics and hospitals They collaborate with the employment agencies and are thus able to play an important part in the rehabilitation of patients discharged from hospitals They are in a position to study the environment in which the patient lives and the nature of his home and working life and to exercise surveillance over the workers in co-operation with social workers in factories and offices, so as to ensure that the basic rules of mental hygiene are observed they are also responsible for calling in the psychiatrist in case of necessity

This system of mental welfare has also been extended to children. The social services concerned with abandoned, asocial or delinquent children have been developed into a general welfare system for children of school age Nervous disorders and defects in speech as well as the "social neuroses appearing during the critical years of adolescence can thus be treated as soon as they become apparent. Child guidance clinics give advice to children, parents and teachers, and when necessary take any medical or social measures which are required.

(*c*) study of automatic disinsectization procedures applicable to aircraft with pressurized cabins,[3]

(*d*) drawing up of "standard instructions" for disinsectization adapted to the different types of aircraft in use on international airlines and suitable for posting in the interior of aircraft

[3] A pressurized cabin is an air tight cabin kept under constant pressure

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves Selections from these reports have therefore been published from time to time but it must be emphasized that the opinions expressed are those of the Fellows

Psychiatry in England

Dr E. F Pakesch Chief Assistant at the Neuropsychiatric Clinic of the University of Gra (Austria) spent six months in the United Kingdom as a WHO Fellow in order to study modern techniques in neurology Apart from his work in clinics and hospitals Dr Pakesch was also able during his stay to study the mental health programmes at present being carried out in the United Kingdom He has published an article on this subject entitled Psychologische Medizin in England [1] the essentials of which are summarized below

During the past twenty years psychiatry has developed considerably in the Anglo American countries Instead of being as formerly an observational science limited to the study of the harmful social elements against which society must protect itself it has become a practical science to which an active and educational role has been assigned and which is assuming increasing importance in the life both of individuals and of the community The experiment now taking place in England shows what part psychiatry when backed by the public authorities can play in the social life of a country

According to Dr Pakesch the scientific theories behind this development are to be found in the new concepts which the psychology of the subconscious has introduced and which have far removed psychological medicine from classical psychiatry as understood by Kraepelin The application of the methods of analytical psychology and of the theory of behaviourism has led to a dynamic conception of psychiatry to which the work of Adolf Meyer and his school on the biological nature of reactions has lent

[1] Pakesch E F (1949) *Wien Z inn Med* 30 1 4

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(Separate editions in English and in French)

Vol. 2, No 2, to be published shortly will include the following articles

Disinsectization of aircraft — *J Duguet*

On pethidine and methadone derivatives — *P O Wolff*

The biological unit of activity its status and scope — *A A Miles*

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Thanks to this organization of mental health services the mass of the population has become familar with the principles and practice of the psychological sciences The psychiatrist now plays an important part in the State and is treated with great respect being at the same time a friend guarding the individual against society and a protector of the interests of the community

Notes and News

Biological Standardization

Some of the decisions taken by the Expert Committee on Biological Standardization deserve being brought to the notice of interested laboratories before such time as the report of the committee is published in full in the *Official Records of the World Health Organization*

Unification of the US and International Units of Tetanus Antitoxin

As from 1 July 1950 all new issues of tetanus antitoxin should cease to be labelled in both international and USA units The Expert Committee on Biological Standardization agreed that the weight of the international standard preparation to which international unit potency is at present assigned should in future be doubled so that the international unit for tetanus antitoxin will be equal to the US National Institutes of Health unit

Turbidity Standard Reference Vaccine and Test Culture used in the USA for the Assay of Anti Whooping Cough Vaccine

Laboratories interested in estimating the number of organisms present in a sample of anti whooping-cough vaccine may apply to the World Health Organization Geneva for the turbidity standard of the US National Institutes of Health which consists of a suspension of particles of Pyrex glass Samples of the reference standard vaccine and test culture for use in conjunction with the US turbidity standard may be obtained from Dr W G Workman Chief Biologics Control Laboratory National Institutes of Health Bethesda Md The Expert Committee on Biological Standardization would be glad to receive the opinion of research workers as to the suitability of the turbidity standard for such antipertussis vaccine counts

Withdrawal of International Biological Standards for Oestrone and Oestradiol Monobenzoate

The issue of the international standards for oestrone and oestradiol monobenzoate will cease as from 1 January 1951 The Expert Committee on Biological Standardization considers that these standards no longer serve a useful purpose as international biological standards the pure substance being now definable by physicochemical analysis

Note — The index to the *Chronicle of the World Health Organization 1948* Volume 2 will be issued with the next number of the *Chronicle* which will be a double number devoted to an account of the proceedings of the Second World Health Assembly Rome 13 June 2 July 1949

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

SECOND WORLD HEALTH ASSEMBLY

The peoples of the world must do more than attempt to protect their health and well being by defensive measures A new outlook is necessary Indifference inertia and resistance hamper and sometimes completely defeat even carefully constructed and thoughtfully presented programmes for improving existing conditions But if we as the experts in health fail to develop and advocate the most far sighted and sound programme that we are capable of producing for improving the health of the peoples of the world then we shall have failed in our responsibility to take all necessary action to attain the objecti e of the Organi ation

Brock Chisholm [1]

GENERAL ACCOUNT

Any attempt to assess the achievements of the Second World Health mbly would be incomplete if account were taken only of the action ned for the control of certain individual diseases—important and reaching although many of these measures undoubtedly were

For such an assessment truly to reflect the work of the Health Assembly ust convey something of the spirit of mutual understanding com mise and co operation which alone made possible the reaching of ement upon many difficult problems It must give due weight to the er and more enterprising methods of approach to such problems ch found expression in the debates and resolutions

The Health Assembly attended by the delegates of 54 Member States esentatives of the United Nations and its specialized agencies and ervers from 5 non member States and 21 international organizations [2] ned in Rome on 13 June and concluded on 2 July after three weeks

Off R World Hlth Org 18 1

For list f deleg tes and observers, see p ge ...3

CONTENTS

This treble number of the Chronicle is devoted to an account of the Second World Health Assembly which was held in Rome from 13 June to 2 July 1949. The official proceedings of the Second Health Assembly comprising decisions and resolutions verbatim records of the plenary meetings and minutes and reports of the main committees will be published shortly as Official Records of the World Health Organization *No 21*

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Note — The *Chronicle of the World Health Organization* is published monthly in English French, Russian, Spanish and Chinese. The *Chronicle* reports the activities of the Organization, without, however claiming to be an authoritative record of its official views which are set out in the *Official Records of the World Health Organization*. All correspondence relating to it should be addressed to the World Health Organization, Palais des Nations Geneva. Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom more especially in the medical Press are entirely at liberty to do so



FIG 1 Centre : Mr Luigi Einaudi President of the Italian Republic e ri ing at the Palazzo Ve ezia for the opening of the Second World Health Assembly ; right : Dr A Stampar President of the First Health Assembly

of intensive work The results of such labour—the programme for the Organization for the year 1950—are outlined in the subsequent pages Few, if any, of the participants, however, returned to their countries in a mood of undue self-congratulation over what had been accomplished, the debates had brought home to all of them a fuller realization of the immensity of the tasks that still lay ahead

The general tenor of the discussions no less than the decisions to which they led made it apparent that the enlightened public health officer is conscious of the need for the new outlook to which reference has been made by Dr Brock Chisholm The adoption of a programme of joint action with the Food and Agriculture Organization (FAO) to raise health standards and increase food production in underdeveloped areas the application on an international scale of the principle of health demonstration areas ', the beginnings (cautious and limited though they must be) of long term campaigns aiming at the eventual elimination of some of the age old scourges such as cholera and malaria—these illustrate some of the newer methods of approach which the Health Assembly decided to use in the fight against disease

The economic aspects—the bearing of health on man hours of labour and on units of production—were of particular concern to the Second Health Assembly The conception of health as a national asset is of course not new, but in recent years there has been a greatly increased awareness of the importance of public health to the economic life of a community

The President of the Second Health Assembly, Dr K Evang summarized this point of view in his presidential address

> we being responsible for the health of the world, have to drive home time and again that unless the peoples of the world enjoy a certain degree of physical and mental health, which they have till now by no means reached all the plans of the economist will be in vain all his programmes will go to pieces

This fact has been recognized too in the United Nations programme of 'Technical assistance for economic development in underdeveloped areas' in which WHO will participate along with other specialized agencies WHO was the first of the specialized agencies to make specific provision for taking part in the project which has been described as a comprehensive plan for an expanded co operative programme of technical assistance for economic development through the United Nations and its specialized agencies, paying due attention to questions of a social nature which directly condition economic development'

The WHO programme for 1950 is accordingly based not only on a regular budget financed in the normal way through the assessed contribu

* Technical assistance for economic development United Nations document E/1327 Add 1 May 1949

on Programme at the First Health Assembly and later as Vice Chairman of the Executive Board

The Health Assembly elected Professor Cotellessa Honorary President and chose as its three vice presidents Mr S W R D Bandaranaike (Ceylon) Dr Naguib Scander Pasha (Egypt) and Dr Jose Zozaya (Mexico)

The Task—and the Budget

The basic working paper before the Health Assembly was the *Programme and budget estimates for 1950* published as a 170-page volume *(Official Records of the World Health Organization* 18*)* This contained not only detailed budget estimates but an analysis of each subject treated a statement of the problem and an appraisal of its significance an account of work already done together with a statement of objectives long term and immediate and finally an outline of the work proposed for 1950

The Executive Board submitted to the Health Assembly the rather novel proposal to which reference has already been made suggesting both a regular budget and a supplemental operating programme of advisory and technical services The amounts proposed for each were $8 193 000 and $9 152 520 respectively —a total of some seventeen million dollars This method of presentation had the advantage of keeping the assessed contributions of Member States relatively low and at the same time giving scope for voluntary contributions

The Health Assembly endorsed this principle and approved a programme to be financed from the regular budget to the amount of $7 501 500 of which sum seven million dollars are to be obtained from the assessed contributions of Member States the remainder being made up mainly of an amount received from UNRRA and contributions for 1949 of new Members The Assembly also approved a programme of advisory and technical services requiring for its full implementation a sum of $10 624 410

The essential task therefore of the Health Assembly was to produce a co-ordinated programme taking into account relative needs in many different fields and making balanced provision for both the regular and supplementary programmes To facilitate its task it set up early in the session three main committees on each of which all delegations were represented

The Committee on Programme had the task of discussing each subject in its technical as distinct from its financial aspects the Committee on Administration and Finance considered all financial implications and prepared a final budget while the third committee was concerned with constitutional matters

It was difficult in practice to make a clear separation between the functions of the Committees on Programme and on Administration and

tions of Member States, but also on a supplemental budget for an operating programme of advisory and technical services which will be financed by additional contributions from Member States on a voluntary basis

The Italian Government had kindly placed at the disposal of the Health Assembly the historic Palazzo Venezia The first plenary session held in the largest room of the Palazzo, the Sala Regia heard the retiring President Dr A Stampar, deliver the opening address He recalled the inception and traced the growth of the Organization, pointing out that it now had one of the largest memberships of any of the specialized agencies the Constitution having been ratified or accepted by 62 Member States [4]

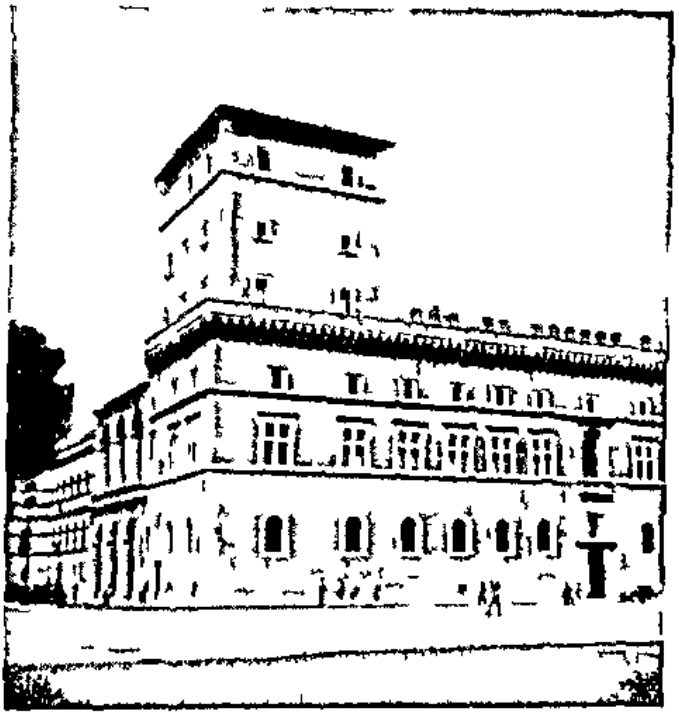


FIG 2 Palazzo Venezia Rome site of the Second World Health Assembly

The delegates were welcomed by Signor de Gasperi President of the Italian Council of Ministers who spoke of the understanding interest with which Italy was following the Organization s work and stressed particularly the value of attacking diseases and epidemics at their source in contrast to the former practice of merely erecting protective barriers against them

Professor M Cotelless a High Commissioner of Hygiene and Public Health and Chief Delegate of Italy likewise welcomed the new international approach which had evolved from the old defensive methods of quarantine towards the infinitely higher objective of a state of health and well being for the whole world

Dr K Evang, Director General of Public Health Norway was unanimously elected President [5] Possessing a wide experience in international health matters as well as in parliamentary procedure he had already given proof of his unusual abilities both as Chairman of the Committee

Subsequent ratifications of the Constitution have brought the membership to a total of 64

For biographical note see page 16

far from their home areas WHO should establish international training centres within the framework of regional organizations and encourage group training The suggestion was taken up by the Health Assembly in a resolution requesting the Director General to arrange fellowships on a group basis as far as possible it being understood however that the granting of individual fellowships would not thereby be ruled out



FIG 3. M A de Gasperi Italia Prime Minister addressi g the Second Health Assembly

The programme of venereal-disease control was also the subject of considerable debate mainly on a proposal by the delegate of Iraq that bejel should be studied by WHO It was decided that a new expert group should be set up consisting of experts on syphilis drawn from the present Expert Committee on Venereal Infections along with six experts on other treponematoses

The Health Assembly went on to establish programmes providing for various types of services to Member States in tuberculosis malaria environ mental sanitation nutrition mental health and public health administra tion The work done in 1949 in these subjects will be expanded in 1950 for most of the programmes the allocations (regular and supplemental) were more than doubled

Among the new ideas put forward in the debate on tuberculosis was a joint proposal by the delegations of Czechoslovakia Denmark, Finland

Finance , in consequence there were, towards the end of the session a number of joint meetings of these two committees at which the technical and financial points of view were considered and solutions reached A sound foundation was thus laid for the work to be carried out in 1950

Under the dual budgetary system it was possible for items removed from the regular budget to become priority claims on the supplemental budget

The Health Assembly specifically instructed the Executive Board in carrying out the supplementary operating programme, to give chief consider ation to

(1) those items transferred from the regular operating programme and such part of the administrative provisions as may be appropriate

(2) strengthening or augmenting technical services ,

(3) technical training of medical and auxiliary personnel ,

(4) malaria maternal and child health, environmental sanitation venereal diseases, tuberculosis and nutrition ,

(5) programme supply advisory services

Consideration of the programme and budget was preceded by an exchange of views based on the Director General's report for 1948 and the reports of the Executive Board

Representatives of war devastated countries took the opportunity of expressing appreciation of the help they had received from WHO in the form of expert advice medical literature and equipment visiting lecturers and fellowships Most of the delegates spoke also of the valuable practical work done by the technical services in the dissemination of epidemiological information, the standardization of biological substances the unification of pharmacopoeias and the control of habit forming drugs Praise of the Organization s work was not unmixed some of the delegations had constructive criticism to offer Without exception however they expressed their faith in the value of the Organization s work

Main Decisions on Programme

The first week s discussions brought ready agreement upon greatly expanded programmes in maternal and child health the education and training of health personnel and the control of venereal diseases

In the discussion on the technical training of medical and auxiliary personnel an interesting proposal which may well prove a turning point in the policy of granting fellowships, was put forward by Dr J Holm (Denmark) He urged that instead of sending individual Fellows to places

far from their home areas WHO should establish international training centres within the framework of regional organizations and encourage group training The suggestion was taken up by the Health Assembly in a resolution requesting the Director General to arrange fellowships on a group basis as far as possible it being understood however that the granting of individual fellowships would not thereby be ruled out



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and India that WHO should appoint a full time tuberculosis officer in each regional office rather than send specialist short term consultants to various countries to collect data and advise the governments concerned Much was said for and against this proposal, but as it would entail a fundamental change in the policy of WHO the Health Assembly preferred to refer the matter to the Executive Board for further study



FIG 4 Dr K Evang President of the Second Health Assembly

The Health Assembly took a significant step in bringing mental health into the area of international action and the establishment of a programme for mental health is in accordance with the conception of health expressed in the Constitution as a state of complete physical mental and social well being

One of the most interesting decisions was that which provided for the setting up of health demonstration areas This type of project has been tried out before on the national level but its application to international health work is entirely new The programme calls for the selection in various parts of the world of areas where a combined attack will be made on one or more major diseases the object being to demonstrate to the governments and peoples of underdeveloped areas what can be achieved through the use of modern public health methods and techniques

Another far reaching project, undertaken jointly with FAO has the dual aim of increasing food production and raising standards of health in underdeveloped areas The plan which contemplates a series of operations extending over five years will be applied to approximately ten million acres of agricultural land, the inhabitants of which, debilitated by malaria are unable to wrest more than a bare subsistence from the soil

The question of medical supplies again proved a subject on which widely divergent views were expressed a compromise being finally reached whereby the Organization will make these available to governments on a limited scale and under special circumstances

Another new subject for action by WHO is leprosy Cogent arguments were advanced for the inclusion of this subject in the programme among them the necessity of encouraging preventive measures throughout the world the hopes raised by certain new therapeutic agents such as the sulphones and the generally recognized need for more research The Health Assembly accordingly approved a series of measures designed to assist in combating the disease which included provision for an expert committee to advise on a rational international campaign

In a decision carrying important implications for the future the Health Assembly approved the principles proposed by the Expert Committee on International Epidemiology and Quarantine for the framing of the WHO sanitary regulations which will replace the present international sanitary conventions This decision may well mark the opening of a new era in international epidemic control in which the aggressive approach" aiming at the suppression of foci of epidemic disease will ultimately replace the conception of protective barriers

These decisions and other aspects of the programme are discussed more fully in the sections which follow The constitutional and administrative decisions taken by the Health Assembly are also discussed elsewhere in this issue

Officers of the Committees

The officers of the main committees were as follows

Committee on Administration and Finance Chairman Dr B Schober (Czechoslovakia) Vice Chairman Dr L F Thomen (Dominican Republic) Rapporteur Mr T Lindsay (United Kingdom)

Committee on Constitutional Matters Chairman Dr P Vollenweider (Switzerland) Vice Chairman Dr L S Davis (New Zealand) Rapporteur Mr H B Calderwood (United States of America)

Committee on Programme Chairman Dr H Hyde (United States of America) Vice Chairman Dr Irène Domanska (Poland) Rapporteur Dr A H Radji (Iran)

The General Committee which co-ordinated the work of the Health Assembly consisted of the President and the three vice presidents the chairmen of the three main committees and delegates of Australia Brazil France India Liberia Pakistan the United Kingdom and Yugoslavia

and India that WHO should appoint a full time tuberculosis officer in each regional office rather than send specialist short term consultants to various countries to collect data and advise the governments concerned Much was said for and against this proposal, but as it would entail a fundamental change in the policy of WHO, the Health Assembly preferred to refer the matter to the Executive Board for further study



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TECHNICAL QUESTIONS

WORLD FOOD-PRODUCTION AND STANDARDS OF HEALTH

Joint FAO and WHO Programme

A broad scale project for malaria control and rural rehabilitation to be carried out in co-operation with interested governments and FAO was approved in principle by the Second Health Assembly Its object is to increase food production in areas capable of agricultural development and in which ill health in particular endemic malaria is the chief obstacle to such development This plan it is hoped will contribute towards decreasing the deficit in world food production and at the same time towards improving the health of millions of people problems which have been debated by the General Assembly of the United Nations and by the Economic and Social Council [6] The total acreage to be dealt with under such a plan must be sufficiently large to cause a significant increase in agricultural production In the proposal for joint action to increase world food production and raise standards of health presented by FAO and WHO to the Central Committee of UNRRA in 1948 it was stated that the total area for such a project was expected to cover at least ten million acres of agricultural land inadequately worked by disease ridden people

The programme will last at least five years (1951 1955) and the operations will reach full scale only in 1951 The tentative timetable will be as follows

1949 preliminary selection of six areas by FAO/WHO

1950 joint area selection surveys of six areas at appropriate seasons

fourth quarter of 1950 final selection of three areas procurement of supplies and equipment and recruitment of personnel

first quarter of 1951 pre operational detailed survey

second quarter of 1951 to end of 1955 operations

As the choice of areas will be based upon the agricultural potentialities the preliminary selection is expected to be made by FAO WHO will then examine these areas concentrating on those where poor health and particularly malaria represent a major obstacle to development where malaria would be amenable to control and where such control would be economically feasible

Once these areas have been provisionally selected by agreement between the two organizations joint area selection survey teams will be sent into the field for a period of not less than three months to examine local

[6] *Technical assistance for economic development* United Nations document E/1327 Add. 1 May 1949

The Nominations Committee was composed of delegates of the following 12 countries Brazil, Bulgaria Canada Czechoslovakia, El Salvador, India Liberia New Zealand, Saudi Arabia, Sweden, Switzerland and Turkey

Professor G A Canaperia (Italy) was chairman of the Committee on Credentials

acres each were selected the total cost for WHO participation in 1951 would be approximately $1 468 000 The first year of operation would include however a capital expenditure which would not be repeated and as the international personnel would devote much of its time to the training of national personnel it was probable that in the latter years the expense for WHO staff would fall

The Health Assembly after consideration of the plan submitted by the Director General [7] resolved that the 1950 programme should include provision to enable WHO to collaborate with FAO in general surveys for the selection of areas in which operations would be undertaken in succeeding years The Health Assembly also recognized that such provision would entail an obligation to collaborate in the following five years in the operation of the various projects and recommended that FAO should take similar action so that the two organizations should be able to plan the projects in 1949 and to initiate joint surveys in 1950

HEALTH DEMONSTRATION AREAS

The conception of health demonstration areas is new in international health work As adopted by the Second Health Assembly the programme entails the selection of several areas in various parts of the world where a combined attack can be made on a number of diseases and adverse environ mental conditions and where a programme of health promotion can be developed to illustrate the results which can be obtained from a rational application of modern public health methods

It is generally recognized that one of the chief problems confronting the public health worker in underdeveloped countries is to find ways and means of bringing to the people the benefits of modern medical services and public health organization in a form suited to their social economic cultural and biological environments and to the potentialities of the area In general the chief diseases which cripple the populations of such areas are those most susceptible to the eradication approach —for example malaria cholera relapsing fever and plague Maternal infant and child hood mortality are high enteric and other diseases resulting from un favourable environmental sanitation are common Tuberculosis and venereal disease control is absent or very inadequate Officials trained to organize a public health programme are little known while there is in addition a great shortage of public health nurses sanitary engineers health edu cationists nutritionists and other professional and technical workers who could develop the programme and assist in training more workers for the necessary follow up programmes of health services and care

[7] To be published in *Off Rec World Hlth Org* 21

conditions and supply the data on which the final choice will be made Six areas in all will be surveyed, while three will be selected jointly by the two organizations

This joint survey will require the fullest co operation of the governments concerned and more specifically their agreement to collaborate technically and financially as far as possible and to give complete assistance to FAO and WHO in operations , as well as to maintain the control measures and the level of development within the areas when the assistance of the two organizations is withdrawn

During the pre operational detailed survey specialized personnel will

(*a*) carry out a detailed malaria survey of the area with a view to planning the control operations

(*b*) carry out a general public health survey paying proper attention to nutrition and other major public health problems

(*c*) plan the operation for the five year period

(*d*) negotiate with the government concerned an agreement on the basis of such a plan

(*e*) train local personnel for the 1951 1955 campaign



FIG 5 Left to right Dr Brock Chisholm Director General Dr K Evang President Professor M Cotellessa Honorary President

At this stage it was not possible to submit detailed budgetary estimates but the Health Assembly was informed that if three areas of two million

Moreover an active desire for such a programme must exist and the full co-operation of the authorities in the area should be assured in advance There should also be some local contribution to the operation either in kind or by the participation of local personnel

It was finally decided that the delegates of the United States of America and India should be invited to prepare a paper in consultation with the Director General combining the principles elaborated during the meeting of the Committee on Programme and those proposed by the Director General The new statement[1] on the principles to be followed by the Organization in establishing health demonstration areas was unanimously adopted by the Health Assembly

The statement lays down as the first criterion careful selection of the area in which the health demonstrations are to be carried out and enunciates certain guiding principles towards that end

Other prerequisites are an assessment of health needs and available resources and also of the environment— health cultural social and economic factors being taken into account

The next phases will be development of a programme of action designed to fit the con text commencement of operations with both short and long term objectives continuous analysis and appraisal of progress made and results obtained and adaptation and applica tion of this experience and information for the benefit of other areas countries and health ad ministrations Through out the demonstration great care will be taken to keep the people in the area informed of



FIG 7 D J Zozaya Vice-Preside t of the Seco d Health Assembly

[1] To be published in *Off Rec World Hlth Org* 21



FIG 6 Left Dr N Scander Pasha Vice President of the Second Health Assembly right Dr M Nazif Bey Egypt

The importance of a solution to these problems cannot be over estimated since without such a solution a considerable part of the work on which great hopes are pinned by many peoples and governments will be severely prejudiced It is believed that the plan for health demonstration areas offers the key to this problem

Such an undertaking however, cannot be successful unless governments in the area co operate with WHO and unless it includes all the specialities and techniques needed to deal with the health problems in the selected area In order to popularize the programme with the inhabitants the area should contain one or more reservoirs of a disease against which eradication methods can readily be demonstrated, it should also form a training ground for personnel both of the countries concerned and from outside

Delegations of various countries, including Australia the United Kingdom, India Union of South Africa Brazil and the United States of America considered the setting up of health demonstration areas to be one of the most important activities of WHO not only in 1950 but also in the years following One of the delegates from the United States of America sounded, however a note of warning and reminded the Health Assembly that while, with proper planning—not only for short term projects but also for long range continuing programmes—the establishment of health demonstration areas could be one of the most valuable activities of WHO, without such careful planning there could be a waste of manpower and money

It was felt that the original plan [8] did not embody all the principles which must be observed if the enterprise was to be successful A demonstration operation should not be established without previous consideration of the financial and technical ability of the country or of the jurisdiction to continue the work after the withdrawal of the demonstration personnel

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(*b*) providing opportunities for the training of personnel primarily active in different fields of health as specified by the WHO programme but not necessarily limited thereto " [10]

In approving these objectives the Health Assembly endorsed with slight amendments the programme of the Director General which called for regular and supplemental budgets of $868 000 and $1 964 000 respectively The 1950 fellowship programme will reflect the emphasis placed on various programmes by the Health Assembly

An important new departure in WHO policy was supported at the Health Assembly by Dr J Holm (Denmark) who felt that the organization of regular courses for group training in various parts of the world would meet existing needs much more effectively than the sending of individual Fellows to study in places far from their home areas He recognized that difficulties existed owing to the lack in some countries of suitable institutes and of experts to carry out this work but felt that the task was worthy of WHO s attention Direct help in equipment salaries and teaching personnel might be given by WHO to suitable institutes in areas needing assistance these institutes to serve as international training centres for all the countries in the area

The above suggestion received much support The possible danger that underdeveloped areas might remain satisfied with the level of training of the personnel in their regions was however pointed out by Colonel M K Afridi (Pakistan) who felt that social and cultural contact with foreign countries was of great value in developing a wider outlook

After the question had been thoroughly studied by a working party it was finally decided that fellowships should be arranged as far as possible on a group basis without however excluding the possibility of individual fellowships and that governments should be encouraged to establish and develop national educational institutes for public health as well as to develop international courses at institutes already in existence or to be created by the provision of assistance in personnel and material

The need for extensive measures by WHO is undeniably great. A ratio of one physician to approximately 1 000-1 500 inhabitants is generally considered the minimum for the proper organization of medical and health care for an average community In fact the ratio differs widely from country to country and in different areas within the same country the variation being particularly evident when urban and rural or wealthy and poor areas are compared Similar differences exist in regard to training opportunities for doctors and other health personnel and it is quite evident also that the training of health personnel must be constantly adjusted to progress in science and to economic and social developments Not all countries can keep pace with this progress and they need help especially in

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and to encourage them to participate personally in whatever health practices are adopted During the operation the work will be carried out in co operation with the health staff of the area or country concerned fellowships will be granted not only to members of these staffs to study in schools of public health and related subjects but also to provide opportunities for training and field practice for medical and auxiliary personnel from adjacent areas and countries where comparable conditions exist so that they will be able to observe and participate in the demonstrations and become familiar with the techniques applied and evolved and with the results achieved They will then be in a position to carry that knowledge back to their own areas or countries

TECHNICAL TRAINING OF MEDICAL AND AUXILIARY PERSONNEL

International collaboration in technical training has been a concern of various bodies, such as the Health Organization of the League of Nations, UNRRA the Rockefeller Foundation UNESCO and UNICEF and their efforts have yielded good results The activities of the first two of these organizations were taken over by WHO in the early days of the Interim Commission

The aim of WHO is both to assist in increasing the numbers of qualified medical and auxiliary personnel and to ensure that their training is of a requisite internationally acceptable standard

Full realization of this aim will require many years but certain immediate objectives have been set for 1950 by the Health Assembly

(1) to assist individual countries in raising the standards of training to an internationally acceptable level

(2) to assist in increasing training facilities in areas where a dearth of medical care is caused by the lack of local personnel

(3) to carry out an analysis of medical curricula including methods of teaching and the material taught and to make recommendations derived from this analysis particular emphasis to be laid on hygiene public health and preventive and social medicine and child health similar analysis of curricula of other professions related to public health

(4) The programme of technical training for medical and auxiliary personnel through the provision of fellowships will be available to governments in order to strengthen health services and thereby raise the level of health of the peoples by

(*a*) promoting the international exchange of scientific knowledge and techniques in public health and medicine

with medical supplies in the same way It was pointed out that the amount of assistance which WHO could furnish if it engaged in direct supplies to governments was infinitesimal in relation to world needs

The opposing view was just as definite It was contended that over wide areas essential health services could not be undertaken because the necessary supplies were not available and that the main health needs of many countries particularly in Europe were not for advisory services but for supplies Maintaining that the fulfilment of certain national health projects was in the interest of the health of all peoples the exponents of this view held that it was a function of WHO in the present situation, to provide essential medical supplies which countries were unable to obtain by local production or by importation

The attitude adopted by the Executive Board on the question is outlined in the letter transmitting the programme and budget estimates for 1950 to the Health Assembly the relevant passage of which reads

Although the Board recognizes the critical need for health and medical supplies in many areas of the world it believes that the distribution of these commodities is basically an economic problem The Board feels that one of the functions of WHO is to assist and support governments in the utilization of international economic machinery in efforts to obtain supplies for health purposes

Whereas WHO should provide supplies required for its own work including its demonstration teams the Board is of the opinion that it is not within the province of nor is it possible for the Organization to make itself responsible for supplies required by governments However the Board recognizes that it may be desirable in some cases for supplies to be made available for specific projects examined in advance in detail and approved by the Executive Board either to continue the implementation of programmes after the WHO demonstration teams have finished their task or to implement or further a health project carried out by a governmental health administration " [11]

In the course of the prolonged discussion which ensued many delegates disputed these principles Dr A Stampar (Yugoslavia) instanced the position of countries which had highly trained health personnel but were unable to carry out their health programmes because they could not obtain essential medical supplies Dr P Tagaroff (Bulgaria) queried the value of sending demonstration teams to countries needing assistance if the products necessary to continue the programmes demonstrated were unobtainable Other delegates among them Dr K C K. E. Raja (India) asked not for a direct issue of essential medical supplies but that WHO should assist govern

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certain highly specialized fields such as laboratory research or new and complicated methods of treatment

While the dearth of doctors is evident in many countries the serious shortage of nurses is universal and there is also an evident shortage of specialists in public health For this last group which includes public health physicians health officers, public health nurses, sanitary inspectors and sanitary engineers special international efforts are needed to bring about an increase in training facilities

MEDICAL SUPPLIES TO GOVERNMENTS

Medical supplies was one of the most controversial matters before the Health Assembly and was the subject of much discussion in the Committee on Programme

The main point at issue was whether or not WHO should provide medical supplies such as DDT, penicillin and streptomycin to countries which do not produce these commodities and which because of shortage of the necessary currencies are unable to import them in the quantities required for carrying out national health projects One view was that the time for the emergency distribu tion of supplies by relief organizations which was proper to the imme diate postwar period was now over Medical supplies like other com modities should now be covered through the normal peacetime economic machinery Various international organizations had been established for the pur pose of analysing the needs of countries and finding 'solutions to problems of production and distribution relating to other commodities and it was appropriate that they should deal



FIG 8 Left Dr W G Wickremesinghe Ceylon right Mr S W R D Bandaranaike Vice President of the Second Health Assembly

by WHO or even for the provision of further supplies for other approved programmes to be undertaken by the government in question In this way the very payments which governments make for the medical supplies they receive through WHO will be used for the further improvement of their own health services

MALARIA

The proposals put forward by the Director General for the malaria programme in 1950[13] provided a wide field for discussion and interesting suggestions on various aspects of the subject were made by a number of delegations

The measures approved by the Second Health Assembly which are designed primarily to encourage malaria control represent broadly an expansion of the work carried out in 1949 and include the continuance of expert advisory aid to governments and of malaria-control demonstrations the starting of new demonstrations in 1950 an attack on the problem of African malaria and broad scale projects of malaria control and overall rural rehabilitation the latter to be carried out in collaboration with FAO[14] The Expert Committee on Malaria had suggested in its report[15] that demonstration teams should be allocated to Tropical America Africa and the Western Pacific Area

The expert committee had drawn the attention of the Health Assembly to the need existing in Central Africa and South East Asia for courses in malariology[16] and as a result it was agreed that assistance should be given by WHO in the setting up of such courses For those in Africa an existing medical school or institution will probably be utilized and Singapore University could be the centre for those in Asia in fact the latter would represent a revival of the League of Nations Singapore malaria courses Courses for the Eastern Mediterranean Region are likewise to be set up at the recently established malaria institute in Karachi and technical assistance may be given by WHO to malaria training institutes in Latin America in India and in Europe It is pointed out that it will be necessary to grant an adequate number of fellowships in connexion with all these courses

Of particular interest perhaps is the expansion of the malaria programme planned in relation to the African continent It is generally admitted that malaria has a direct bearing on the possible development of the continent and two African malaria projects were approved by the Second Health Assembly

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See page 166

The report the second session of the Expert Committee on Malaria was published in *Off Rec World Hlth Org* 11 43 and an abridged version in *Bull World Hlth Org* 1948 1 13 See also *Chron. World Hlth Org* 1948 2, 146.

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ments to obtain those needed for national activities at reasonable cost and with reasonable speed

On the other hand, Dr L A Scheele (United States of America) speaking in defence of the policy advocated by the Executive Board, stressed the disadvantages which would result from the Organization's direct intervention in supply matters The diversion to direct supplies to governments of a part of WHO s limited budget would, he suggested mean a consequent reduction in other programmes and would therefore neutralize the constructive efforts of WHO for the progressive improvement of the health of all peoples of the world Supply problems should be left to organizations concerned with economic matters and he opposed any policy which would be a drain on the slender resources of the Organization and which might lead it into political controversy

Finally, after a discussion which lasted for the better part of two long meetings the majority of the delegates accepted the principles proposed by the Executive Board

The effect of this decision is that the general question of supplies is conceded to belong to the activities of the various economic organizations the function of WHO being to stimulate their activity and to co operate with them (as is done with the Economic Commission for Europe in the case of penicillin) [1] On the other hand, side by side with the acceptance of this principle is the recognition that some provision must be made in the programme of WHO for making urgent supplies available to governments where no immediate solution is possible through the normal economic channels The Second Health Assembly therefore approved an allocation of $234 000 from the regular budget with a further $560 000 from the supplemental budget, for supplies to governments (as compared with $150 000 allotted by the First Health Assembly under this head) This sum will be used partly to continue the existing programme of providing medical literature and teaching equipment to countries which either have not yet been able to restore their war damaged libraries or laboratories or which need up to date information on recent developments or again to underdeveloped countries needing nuclear sets of medical literature for the improvement of their medical training facilities In addition however a part of the sum allocated for 1950 will be used to provide in certain cases the medical supplies needed for the continuation of work started by the WHO demonstration teams or for the execution of certain national health schemes approved by WHO In both these cases the government will be expected to pay for the supplies whenever possible Payments will normally take the form of a credit to WHO in local currency and will be used by the Organization for the development of further health schemes in the area for the financing of WHO Fellows for carrying out other health projects

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FIG 9 Opening plenary meeting of the Seco d Health Assembly The Ital an Pres dent and members of the Itall n Cabi et in fo eground

Two opposing points of view emerged from the debate on the proposal The Italian viewpoint as expounded by Professor Corradetti was that all activities and funds of WHO relating to insect borne diseases should be co ordinated an aim which would be realized by widening the terms of reference of the Expert Committee on Malaria as suggested

Ample practical justification for such a step existed The introduction of contact insecticides now permitted effective control of numerous insect borne diseases Experience had shown that the spraying of houses with these insecticides for the purpose of malaria control had at the same time proved effective against general mortality and morbidity in fact, in Italy a marked decrease of general and infant mortality had been noted in those regions in which DDT had been used These facts were borne out by experience elsewhere and Professor Corradetti contended that the use of this method could prevent diseases which at present owing to the etiological classification used by WHO appeared in the programme in different sections and with separate funds

Dr A Ejercito (Philippine Republic) opposed this view for the following reasons First malariologists were not in general agreement that the use of DDT was the sole means of combating malaria secondly the problems of malaria were already sufficiently complicated without other subjects being explored by the same expert committee and thirdly the proposed title which was not in accordance with the prominence given in the programme of WHO to malaria implied that all diseases communicated by insects would be studied by the expert committee perhaps including even

It is planned to hold a malaria conference in Equatorial Africa in which all the outstanding experts on African malaria the chiefs of malaria services on the continent (North Africa excluded) and experts of FAO are expected to participate The conference will be purely technical in character, and its broad purpose will be to establish an antimalaria policy for Equatorial Africa In particular, it will advise on the best methods of control applicable in various areas and on the priority of the areas in which large schemes should be undertaken According to original plans the conference should also deal with trypanosomiasis and it was assumed that one third of the experts attending it would be experts in that subject

This latter proposal evoked some criticism at the Assembly, doubts being expressed as to whether the expense involved by the attendance of these experts would be justified

Dr A M W Rae (United Kingdom) and Professor J A H Rodhain (Belgium) placed information before the Committee on Programme from which it would appear that ample data on trypanosomiasis was already available, and that it was therefore unnecessary for WHO to start fresh studies

The second project—an experimental project of vector species eradication in Central Africa—also aroused some comment Professor A Corradetti (Italy) was doubtful of its value it was not clear whether the experiment would be carried out in an *Anopheles funestus* or an *Anopheles gambiae* area, in an area with both these vectors, or in an area with other malaria carrying anopheles further, as the epidemiology of malaria in Central Africa varied considerably according to the region and the altitude the selection of a typical zone for the experiment would present great difficulties In his view any attempt at eradication would entail many experiments in accordance with the many entomological and epidemiological variations that existed, and as a method eradication had proved expensive, and not more effective in preventing malaria than the treatment of habitations by contact insecticide sprays

Both the malaria conference and the vector species eradication experiment were finally approved by the Assembly on the understanding that the views expressed in the discussion would be taken into account when final plans were made

A proposal with deep and far reaching implications was submitted to the Health Assembly by the Italian delegation it was that the present Expert Committee on Malaria should be transformed into an expert committee on malaria and other insect borne diseases and that malaria training courses in different countries should be integrated with training in insect control It was decided that the proposal, which was examined with great interest required further study before a final decision could be made and it was referred to the Executive Board for that purpose

found sufficient in some cases to attach a paediatrician or a public health nurse to another team

The potentialities of work in maternal and child health are apparent from the fact that infant mortality varies today from below 30 per 1 000 live births in some countries to over 300 in others Its wide scope is indicated in the statement introducing the budgetary estimates [17] It is sometimes forgotten that the most widespread and most serious ill health is not due specifically to tuberculosis malaria cholera typhus or indeed to any other single factor but to a concatenation of circumstances which result from dirt and ignorance Food production does not improve only by destruction of weeds Health will not improve greatly by only attacking diseases

" Successful work for maternal and child health is based on teaching people what they can do for themselves It can co operate with the agri cultural and animal husbandry departments to ensure that improvements in nutrition take place in the homes with departments of education social welfare and sanitation to improve the standard of living

The interest taken by the various countries in the efforts of WHO to create positive health through its maternal and child health programme has been clearly demonstrated at both the First and the Second Health Assembly and many requests have been received from governments for one or other of the forms of assistance the programme offers

TUBERCULOSIS

The tuberculosis programme of WHO for 1950 marks a further step in the campaign against tuberculosis The proposals envisage regular and supplementary programmes calling for sums of $340 000 and $265 000 respectively These programmes have been drawn up in recognition of the fact that the time has come for a transition from the emergency measures applied since the war (chiefly in UNRRA aided countries) to a long term worldwide campaign against the disease From a brief survey of the epi demiology of tuberculosis submitted to the Second Health Assembly [18] it was clear that vast regions which had not benefited from UNRRA WHO and other similar organizations in the past were in great need of assistance

As a first step towards a large scale programme it was thought advisable to invite all countries to submit their requests to WHO the Organization will therefore not be in a position to plan in detail for long term objectives before the middle of 1950

[17] *Off Rec World H lth Org* 18 65
[18] *Off Rec World Hlth Org* 18 96

yellow fever dengue and filariasis Thus the specialized identity of the expert committee whose membership was barely sufficient in Dr Ejercito s opinion, to deal with malaria problems would be endangered

This view was supported by Professor A R Dujarric de la Rivière (France) who also pointed out that, if problems regarding insect borne diseases other than malaria were encountered, liaison with the WHO Expert Committee on Insecticides would be relatively easy

A further point was raised by Dr S Klosi (Albania) He was of the opinion that the budgetary estimates for malaria were insufficient particularly in regard to the immediate objectives of the Organization Dr B F Avery (Iran) supported him pointing out that considering the importance of the disease the proportion of the total budget devoted to malaria was insufficient, and that a greater return for the money expended would be obtained by assigning a larger proportion of the budgetary provision to supply of materials to providing leadership and to education and training of local personnel

Regular and supplemental budgets of approximately $375 000 and $803,000 respectively were approved by the Health Assembly

MATERNAL AND CHILD HEALTH

For maternal and child health the Health Assembly considered a 1950 programme calling for a regular budget of $330 000 and a supplemental budget of $740 000 The subject thus ranks among the principal activities of WHO General agreement was quickly reached and the programme was approved with a slight change in the budget

Under this programme WHO will help governments to develop their services and facilities in maternal and child health the form of assistance varying according to the needs and wishes of the government concerned In some cases it will take the form of demonstration teams , in others visiting consultants will give guidance on particular problems Information on all aspects of maternal and child health and welfare will be collected and disseminated for example information on results of research health education and propaganda, and current procedures methods and administrative practices Assistance in the training of personnel will be given through fellowships the organization of courses travelling seminars regional conferences etc

The discussion at the Health Assembly showed that the problems of maternal and child health differ from place to place and require correspondingly different treatment Hence, no definite composition has been laid down for the teams for field work that section of the programme being left as flexible as possible and the way being open for teams to work in conjunction with other health demonstrations It may even be

expert bodies should be created one to deal with venereal diseases in general mainly from the point of view of epidemiology and control the other to deal with treponematoses mainly from the point of view of study and laboratory research or to accept a recommendation put forward by Colonel M K Afridi (Pakistan) that the present WHO Expert Committee on Venereal Diseases should co-opt three members who are experts on other treponematoses such as bejel and yaws

Professor A R Dujarric de la Riviere (France) pointed out that venereal diseases could not be grouped together with treponematoses although the relationship with syphilis was established etiologically if not epidemiologically and suggested that it should be left to the present Expert Committee on Venereal Diseases to consider whether bejel and yaws came within its province



FIG 10 Dr D Pharaon Saudi Arabia at the S cond Health Assembly

Dr W A Timmer man (Netherlands) opposed the proposal to form a new expert committee mainly on economic grounds new expert committees should not be formed unless they were proved to be indispensable to the work of the Organi zation He therefore suggested that the name of the present committee on venereal diseases be changed to Expert Committee on Venereal Diseases and Bejel"

Finally the Executive Board was authorized to establish an expert group on treponematoses consisting of the experts on syphilis of the Expert Committee on Venereal Diseases and six experts on other treponematoses

Among the special activities now approved are the following

(*a*) The development of the WHO serodiagnostic standardization programme [2] including the establishment of international reference centres for test performance and the convening of an international serological laboratory conference, under the guidance of the Sub Committee on Serological Standardization and Laboratory Aspects

(*b*) establishment of a special international demonstration and investigation project in a major port in co operation with ILO and other international organizations interested in maritime aspects of venereal disease control

(*c*) participation in a scheme for the eradication of endemic syphilis in the area of Bosnia Herzegovina Yugoslavia, in view of its scientific national and international interest and the existence of similar areas of high endemicity in Asia and Africa

The only important change to the programme proposed by the Director General was a decision that spirochaetal infections such as bejel and yaws should be studied by a special group of experts consisting of the specialists on syphilis of the Expert Committee on Venereal Diseases and six experts on other treponematoses

The question of bejel had been raised, at the First Health Assembly [3] by the delegate of Iraq who proposed that this disease regarded as mild syphilis should be studied by WHO

Since the classical studies of E H Hudson, it has become apparent that bejel affects large numbers of people in the Middle East and possibly in other parts of the world While the importance of the disease was fully recognized by the First Health Assembly it was pointed out that, without further information bejel could not be considered to be a venereal disease and the question was therefore referred to the Expert Committee on Venereal Diseases

The expert committee took the view that bejel was predominantly non venereally transmitted but this conception did not meet with the unanimous agreement of the Executive Board and the committee was consequently invited to reconsider the problem at a later meeting The question was also placed on the agenda of the Regional Committee for the Eastern Mediterranean Area

The Second Health Assembly was thus confronted with a complicated technical problem From the discussion it appeared that two courses were open to follow the suggestion made by Dr L F Thomen (Dominican Republic) supported by the delegates of Switzerland and Italy, that two

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MENTAL HEALTH

The mental health programme the first of its kind on an international scale was welcomed by the great majority of the delegates to the Second World Health Assembly as an important event in international health co-operation

The need for action by WHO in mental health was widely appreciated and Dr W S Maclay (United Kingdom) expressed the opinion of many delegates when he welcomed the recognition by WHO of the importance of mental health in making it a specific item on the programme with a considerable budget He recalled that mental illness was probably responsible for more unhappiness and economic loss than any other form of illness he added that it was estimated that some 30 / of all the out patients in England and Wales attended for reasons that were largely psychological and that about one third of the discharges from the British Army in 1943 had been on psychiatric grounds Such figures showed that it was essential for money to be spent on the problem of mental illness and the achievement of mental health even if the results could not always be measured in quick returns

The programme as presented by the Director General [30] and as finally adopted is in the nature of a preparation for broader programmes in the future The first step will be to compile information on mental health problems services and educational facilities This will be done partly through written reports and partly by collection of data on the spot

A new aspect in the collection of information will be the surveys to be carried out among sections of the community which even in countries with developed mental health services have been neglected in the past Inquiries will be made into the mental health problems in rural communities in different parts of the world and at different stages of social and economic development Similar surveys will be carried out in industrial units and among students Some surveys will be carried out by visiting teams (to include short term consultants) which will demonstrate new techniques give short training-courses to mental health workers and act as travelling seminars Such teams will thus be able to combine the collection of information with the propagation of new ideas and methods connected with mental health It is intended that liaison will be maintained with the other interested international organizations among them FAO ILO and UNESCO

The decision to adopt the programme of the Director General subject to a reduction of the regular programme to $174 180 the supplemental programme being increased to $768 370 although approved by the majority of delegates was not reached without discussion

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[2] *Chron World Hlth Org* 1948 2 17 1949 3 14
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FIG 11 Se ond Health Assembly in pl ary meeting

in Burma Indo-China Siam and Southern China) but the mortality figures vary from year to year from 100 000 to 500 000 and more—figures which show the magnitude of the task ahead Much work will have to be done and much money spent before any positive results are obtained Yet a start has been made—though modest and cautious—and the new era of aggressive approach to the control of pestilential diseases can thus be said to be opened

Plague

Such a radical approach could not be taken by the Health Assembly with regard to plague Eradication of plague to be complete would require the elimination of infection in wild rodents in vast areas in the Americas in South Africa and in Asia—an impossible task A less ambitious but still difficult objective was approved by the Health Assembly [26] the elimination of plague from endemic areas or small foci where it has persisted for years by the combined use of modern rodenticides and insecticides with residual action by these means sea and airports ships and aircraft can be made plague free and plague proof so as to prevent international transmission of the disease It was decided that two teams similar in composition and functions to the anticholera teams to demonstrate new

[26] *Off Rec World Hlth Org* 18 11

INTERNATIONAL EPIDEMIC CONTROL

The principles proposed by the Expert Committee on International Epidemiology and Quarantine [24] to govern the WHO sanitary regulations which will unify and replace the several existing international sanitary conventions, were approved by the Second Health Assembly Draft texts now being prepared will be considered by the expert committee, meeting in conjunction with the WHO Yellow Fever Panel during December 1949 and later during 1950 when, with the assistance of a group of specialists on juridical matters a final text is expected to result In establishing the WHO sanitary regulations the closest possible collaboration will be maintained with the International Civil Aviation Organization and with those specialized agencies of the United Nations dealing with questions affecting maritime and land transport The Health Assembly drew the attention of national health administrators to the importance of removing quarantine restrictions of doubtful value which interfere with international trade and travel The committee s statement that some health administrations showed a tendency to increase their requirements for compulsory certificates of immunization from travellers was also endorsed by the Health Assembly

Cholera

A first practical step was taken by the Health Assembly in the direction of an ideal long cherished by many public health officers the eradication of cholera It is proposed to send into two districts of the endemic area of Bengal, now divided between India and Pakistan two teams to demonstrate the most efficient modern methods of control Each team would consist of three members (a bacteriologist an epidemiologist and a sanitary engineer) employed by WHO assisted by two local medical officers together with subordinate administrative technical and laboratory staff The control operations would be extended subsequently to adjoining districts so as gradually to reduce the endemic area The two WHO teams would also have the function of forming with the assistance of the local health administration other teams to carry on the work initiated by WHO Field fellowships would therefore have to be granted by WHO to medical officers in the area

The plan is based on the simple fact that it appears advantageous to take the offensive and attempt eradication in well defined endemic areas rather than to keep a continuous and sterile watch in many provinces and countries against cholera invasion [25] Cholera prevails endemically in relatively well-circumscribed areas in Bengal (it exists hypo endemically

[24] *Off Rec Wo ld Hlth Org* 19 7 *Ch on Wo ld Hlth Org* 1949 3 1

[25] *Off Rec World Hlth Org* 18 110

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control methods in infected towns and villages should start work in 1950 The programmes for both the anticholera and antiplague teams are subject to subsequent financial arrangements as no provision has been made in the regular budget for these activities

Typhus

The third and last pestilential disease which is intended to become subject to direct international action is typhus Yet typhus even more than plague lends itself to national rather than to international action The means for delousing entire populations and for maintaining these populations louse free can be possessed only by national health administrations In these circumstances WHO can only provide demonstration of the feasibility and success of such large scale delousing and arrange for the procurement of the necessary insecticide for those countries which for technical or financial reasons, cannot obtain it in the requisite quantities [27] Two demonstration teams have been provided for in the supplemental budget

Other Epidemic Diseases

The Health Assembly also approved a number of epidemiological studies to be undertaken directly by WHO or co ordinated by WHO in 1950 on various diseases such as smallpox yellow fever filariasis trypanosomiasis, leishmaniasis ankylostomiasis poliomyelitis, trachoma and rabies [8]

The Health Assembly approved a proposal that an expert committee on rabies, composed of six members be convened to make recommendations as to the desirability of a conference on rabies and to initiate research in which antirabies institutes would be invited to participate

Finally, provision was made in the programme for 1950 for a special field study group on schistosomiasis [29] Field action is expected to include the sending to an endemic area of a study team composed of an epidemiologist a helminthologist, and a molluscologist to determine the relative value of snail destruction and of other means of control

[8] *Off Rec W ld Hlth Org* 18 114
Off Rec World Hlth Org 18 134
[9] *Off Rec Wo ld Hlth Org* 18 161

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The need for action by WHO in mental health was widely appreciated and Dr W S Maclay (United Kingdom) expressed the opinion of many delegates when he welcomed the recognition by WHO of the importance of mental health in making it a specific item on the programme with a considerable budget He recalled that mental illness was probably responsible for more unhappiness and economic loss than any other form of illness he added that it was estimated that some 30 / of all the out patients in England and Wales attended for reasons that were largely psychological and that about one third of the discharges from the British Army in 1943 had been on psychiatric grounds Such figures showed that it was essential for money to be spent on the problem of mental illness and the achievement of mental health even if the results could not always be measured in quick returns

The programme as presented by the Director General [30] and as finally adopted is in the nature of a preparation for broader programmes in the future The first step will be to compile information on mental health problems services and educational facilities This will be done partly through written reports and partly by collection of data on the spot

A new aspect in the collection of information will be the surveys to be carried out among sections of the community which even in countries with developed mental health services have been neglected in the past Inquiries will be made into the mental health problems in rural communities in different parts of the world and at different stages of social and economic development Similar surveys will be carried out in industrial units and among students Some surveys will be carried out by visiting teams (to include short term consultants) which will demonstrate new techniques give short training-courses to mental health workers and act as travelling seminars Such teams will thus be able to combine the collection of information with the propagation of new ideas and methods connected with mental health It is intended that liaison will be maintained with the other interested international organizations among them FAO ILO and UNESCO

The decision to adopt the programme of the Director General subject to a reduction of the regular programme to $174 180 the supplemental programme being increased to $768 370 although approved by the majority of delegates was not reached without discussion

Off R World Hlth Org 18 77

control methods in infected towns and villages, should start work in 1950 The programmes for both the anticholera and antiplague teams are subject to subsequent financial arrangements as no provision has been made in the regular budget for these activities

Typhus

The third and last pestilential disease which is intended to become subject to direct international action is typhus Yet typhus even more than plague lends itself to national rather than to international action The means for delousing entire populations and for maintaining these populations louse free can be possessed only by national health administrations In these circumstances WHO can only provide demonstration of the feasibility and success of such large scale delousing and arrange for the procurement of the necessary insecticide for those countries which for technical or financial reasons, cannot obtain it in the requisite quantities' [7] Two demonstration teams have been provided for in the supplemental budget

Other Epidemic Diseases

The Health Assembly also approved a number of epidemiological studies to be undertaken directly by WHO or co ordinated by WHO in 1950 on various diseases such as smallpox yellow fever filariasis trypanosomiasis, leishmaniasis ankylostomiasis poliomyelitis trachoma and rabies [28]

The Health Assembly approved a proposal that an expert committee on rabies composed of six members, be convened to make recommendations as to the desirability of a conference on rabies and to initiate research in which antirabies institutes would be invited to participate

Finally provision was made in the programme for 1950 for a special field study group on schistosomiasis [9] Field action is expected to include the sending to an endemic area of a study team composed of an epidemiologist a helminthologist and a malluscologist to determine the relative value of snail destruction and of other means of control

Off Rec World Hlth Org 18 114
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Off Rec World Hlth Org 18 161

The discussion which took place at Rome revealed that some delegates doubted whether at the present time health statistics had received sufficient recognition in the general programme of WHO In a memorandum submitted to the Health Assembly [32] the United Kingdom delegation expressed its conviction that if wasteful expenditure and futile effort are to be reduced to a minimum the programmes of the Organization must be guided by scientifically sound information A consequence of this general proposition is that statistical material and methods should be fully and expertly used in all suitable cases The numerical measurement of a problem is in itself a great safeguard against hasty and confused thought In planning in implementation and in judging results for future guidance health programmes should be founded upon and guided by good statistics For these reasons the United Kingdom delegation hopes that the Organization will encourage the full use of health statistics as an important means of ensuring the successful pursuit of the objectives set forth in its Constitution On the proposal of the United Kingdom delegation the Health Assembly finally resolved that in both field and laboratory investigations as well as in any action carried out by WHO or with its assistance the fullest possible use should be made of available statistics and modern statistical methods It was desirable that wherever suitable health statistics existed or could be made available within a reasonable time they should be examined in order to make a preliminary assessment of the need for the investigation or action contemplated It was however recognized that in many countries such suitable statistics might not be readily available and the Health Assembly considered that their absence or insufficiency should not prevent investigation and action where these were considered necessary This last statement was recognized to be of particular significance since international action would be of assistance to countries where difficulties were experienced in compiling health statistics

The Health Assembly also requested the Executive Board to establish three sub-committees of the Expert Committee on Health Statistics The first of these will study the question of the definition of stillbirth and abortion and the second will initiate the proper action to be taken in the field of hospital statistics The third expert sub-committee was entrusted with the study of problems concerning the registration of cases of cancer as well as their statistical presentation

[32] To be published in *Off. Rec. World Hlth. Org.* 21

A programme of these dimensions was thought by a few delegates to be too extensive for the limited income at present available to the Organization and disproportionate to the programmes suggested for other major problems such as tuberculosis and malaria A different view was taken by the Committee on Programme as a whole, which had the guidance of the technical advisers on mental health to the delegations of Denmark Italy, Sweden, Switzerland and the United States and of the President of the World Federation of Mental Health These advisers examined the programme submitted by the Director General before its consideration in committee and recommended a shifting of the priority among the various items proposed They suggested the transfer of the surveys in rural and industrial communities and on student mental hygiene to the supplementary programme in order to accord first priority to the collection of information on mental health problems and facilities in all countries to the holding of expert committee meetings and to the immediate and extensive development of consultant services

The rearrangement of items among the two parts of the programme involved no change in the totals estimated for the regular and supplemental budgets That rearrangement was considered desirable by the Committee on Programme and was accepted by the joint meeting of the Committees on Programme and on Administration and Finance subject to a transfer of a third of the provision for advisory and demonstration services to the supplemental budget This was one of the modifications in programmes required to reduce the total regular budget from eight to seven million dollars

The mental health programme for 1950 as adopted by the Health Assembly will pave the way for a more comprehensive campaign for the prevention and care of a form of illness which is widespread and which has hitherto been neglected in many regions

HEALTH STATISTICS

An extensive programme on health statistics was approved by the Second Health Assembly The long term objectives of this programme were defined as on the one hand to foster any possible improvement of health statistics in the different countries , on the other hand, to perfect the collection on an international scale of national statistics referring to different phases of public health work and also to shorten as far as is practicable the time for assembling and publishing the systematic conspectus of international health statistics as it is a well known fact that their usefulness and service depend to a great extent on the rapidity with which they become available [31]

[31] Off Rec World Hlth Org 18 151

of WHO had been recognized by the First Health Assembly and in consequence a special section of the Secretariat has been created to deal with the organization of public health services including also problems relating to hospitals clinics and nursing homes medical aid medical rehabilitation medico-social activities nursing industrial hygiene and the hygiene of seafarers In these last two subjects as has been mentioned earlier WHO is collaborating with ILO

ENVIRONMENTAL SANITATION

No permanent advances in the general health programme can rest upon a substructure of poor sanitation Any improvement in the disposal of excreta in the protection of drinking water in the destruction of the fly and the mosquito brings health and social advantage to man woman and child [35]

This statement in the programme proposed by the Director General and adopted by the Health Assembly shows that the importance of environmental sanitation to the health of the community has been fully recognized A sum of approximately $216 000 in the regular budget and approximately $846 000 in the supplemental budget is provided for this aspect of the 1950 programme

All the proposals met with the approval of the Health Assembly and the importance of the subject was emphasized by several speakers It was unanimously recognized that the value of environmental sanitation should not be estimated only in terms of direct results obtained since good environmental sanitation is an essential prerequisite to the control of a number of important diseases and improved sanitation would further the progress of public health in those areas where the people are generally unaware of scientific progress and accept diseases as a necessary part of life This was particularly emphasized by Dr J D MacCormack (Ireland) who believed that to attempt health education by talks and instruction alone was usually a waste of time while DDT-spraying and other methods resulting in the eradication of malaria and insects for example were more likely to render the people receptive to advice given by health workers Dr MacCormack therefore suggested that environmental sanitation should be co ordinated with work for the extermination of endemic diseases and should form a necessary part of the follow up programme in any such scheme

WHO is not however to limit its action to town areas Some sanitary engineers tend to think in terms of sanitary improvement of urban rather than of rural areas but Dr W G Wickremesinghe (Ceylon) warned that the improvement of sanitation in underdeveloped countries was more a

[35] *Off R World Hlth Org* 18 72

PUBLIC-HEALTH ADMINISTRATION

New activities in 1950 will include the establishment of an expert committee on nursing and, provided the necessary financial arrangements can be made in time, an expert committee on public-health administration. Provision has also been made for two joint committees with ILO: the first on occupational hygiene and the second on the hygiene of seafarers. For these and other measures approved by the Health Assembly $145 000 have been allocated in the regular budget and $311 000 in the supplemental[25].

The proposal to establish an expert committee on nursing had already been approved by the First Health Assembly[26] but owing to lack of funds the committee could not be set up in 1949. At the Second Health Assembly during the discussion of this project by the Committee on Programme Miss D. C. Bridges observer from the International Council of Nurses stressed the importance of the professional nurse and medical auxiliary personnel. The Council, which represents some 250 000 nurses drew the attention of the Health Assembly to the fact that in most countries there was a grave shortage of trained personnel for all types of nursing. There was not only a lack of candidates but there were also increased demands for nurses, arising from new forms of medical treatment and from a greater awareness among the public of the need for nursing care.

The importance of public-health administration and the programme

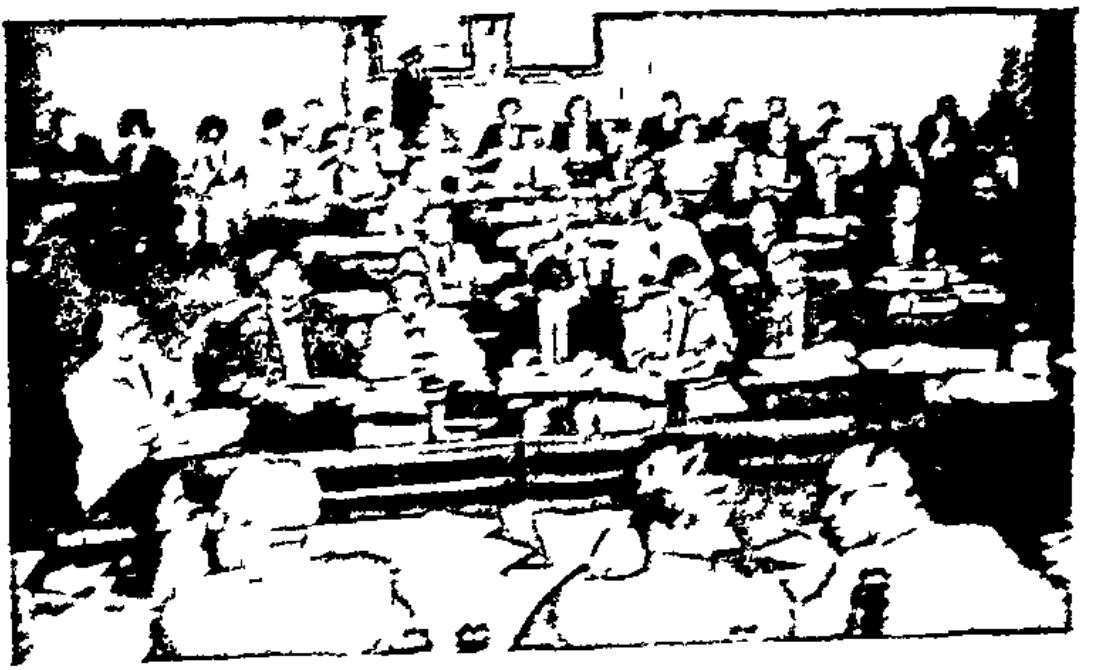


FIG. 12. Second Health Assembly in plenary meeting

[25] Off. Rec. World Hlth Org. 18, 302.
[26] Chron. World Hlth Org. 1948, 2, 379.

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[35] *Off. R. World Hlth Org.* 18, 7

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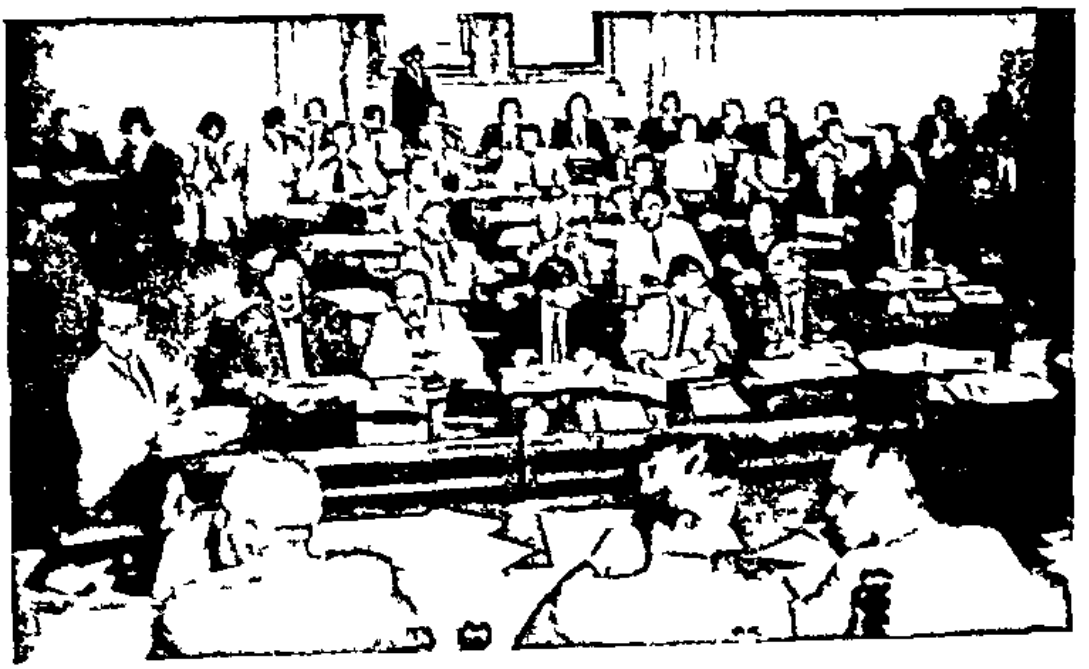


FIG 12 Second Health Assembly in plenary meeting

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LEPROSY

An entirely new subject in the programme of WHO is that of leprosy its discussion at the Second Health Assembly resulted in the approval of a number of measures designed to assist in combating the disease [38]

It was specifically decided that an expert committee with the maximum number of nine members be established to meet if possible for the first time in 1950 Provision was also made for the exchange during 1950 of four selected leprosy workers from among the existing leprosy institutes in different countries and for three experts to be sent for an average period of eight months to countries requiring guidance in the development of antileprosy work Finally provision was made for the supply of sulphones and other new leprosy drugs for control trials by selected leprosy workers under conditions to be laid down by the expert committee

It has been estimated that there are more than three and a half million lepers throughout the world and that more than nine tenths of these are to be found in Asia and Africa in countries where possibilities for carrying out research are very limited The medical profession in other parts of the world cannot shut its eyes to such realities and indeed a keen desire to help the regions in need was shown at the Second Health Assembly

The Committee on Programme heard a statement by Dr R. Chaussinand observer from the International Leprosy Association who said he believed that with the help of modern therapeutic resources leprosy could become a rare disease within the next twenty years provided that an enlightened and well-organized antileprosy campaign could be carried out Unfortunately many countries where the disease was rife had neither qualified personnel nor the funds to finance the necessary programme He therefore commended leprosy control as meriting particular attention by WHO

The establishment of an expert committee in 1950 was called for by the Indian delegation in a memorandum [39] which also proposed the creation at a later stage of a world centre for research in leprosy and various other international measures The memorandum drew attention to the gaps in the knowledge of the disease pointing out that the mode of transmission of infection was not fully understood and that while many encouraging forms of treatment had been tried none had been shown to be so effective as to sterilize the patient completely More knowledge regarding the etiology and pathology of leprosy was necessary before a sound programme of action could be formulated The difficulties presented by the administrative side of the leprosy problem were also stressed in the memorandum the overcrowded and insanitary living conditions of the poorer sections of the people among whom the disease is mainly prevalent and the financial burden entailed by the segregation of sufferers as well as the social diffi

[38] *Off Rec World Hlth Org* 18 140

[39] To be published in *Off Rec World Hlth Org* 21

rural than an urban problem Such projects as town planning, while widely necessary were not the specific problems of WHO which should first stress the two fundamental sanitary requirements of humanity the disposal of human excreta and the provision of safe drinking water

A special project was consequently approved by the Health Assembly, calling for the selection of a rural underdeveloped area in Europe with a population of not more than 100 000 to serve as a WHO demonstration area Local understudies are expected to be attached to the demonstrations fellowships being awarded to workers from other countries for the purpose of studying on the spot The sanitary measures adopted in the demonstra tion area are intended to serve as a model for other areas

Other activities planned for 1950 include collection and dissemination of information on housing, special studies on housing in tropical regions technical advice to governments on urban and rural sanitation and hygiene awarding of fellowships organization of training courses assistance to governments in setting up administrative units for environmental sanitation activities and co operation with the United Nations and various specialized agencies in special undertakings

NUTRITION

In view of the fact that it is perhaps the most important single environ mental factor in health nutrition was given high priority by the First Health Assembly [36] The Second Health Assembly endorsed this view by allocating $63 000 in the regular budget and $323 000 in the supplemental to nutrition

The keynote of the programme will be the closest co-operation with FAO [37] The joint FAO/WHO Expert Committee on Nutrition is to meet in October to consider matters of common interest including the manu facture of synthetic vitamins for underdeveloped countries and a proposal for the establishment of national joint FAO/WHO nutrition committees Other activities will include collaboration in the conducting of training courses and in a series of special projects

WHO will also have an independent programme and during 1950 it is expected that six teams of nutrition experts will be available for attach ment to maternal and child health units or to tuberculosis units or to act independently Each team will consist of two consultants Seven full time consultants will be available for advice to Member countries or regional offices In addition it is expected that there will be ten part time consul tants each of whom will be available for a period of two months

[36] *Ch on. World Hlth Org* 1948 2 177
Off Rec World Hlth Org 18 105

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[38] *Off Rec World Hlth Org* 18 140

[39] To be published in *Off Rec World Hlth Org* 21

culties arising from the separation of patients from their families and homes Moreover, since the countries in which leprosy was an important public health problem had meagre financial resources ill developed health services and other pressing problems there was a tendency for antileprosy work to be relegated to the background

The Health Assembly recognized the validity of the Indian delegation s arguments, and leprosy thus has a place in WHO s programme for the first time

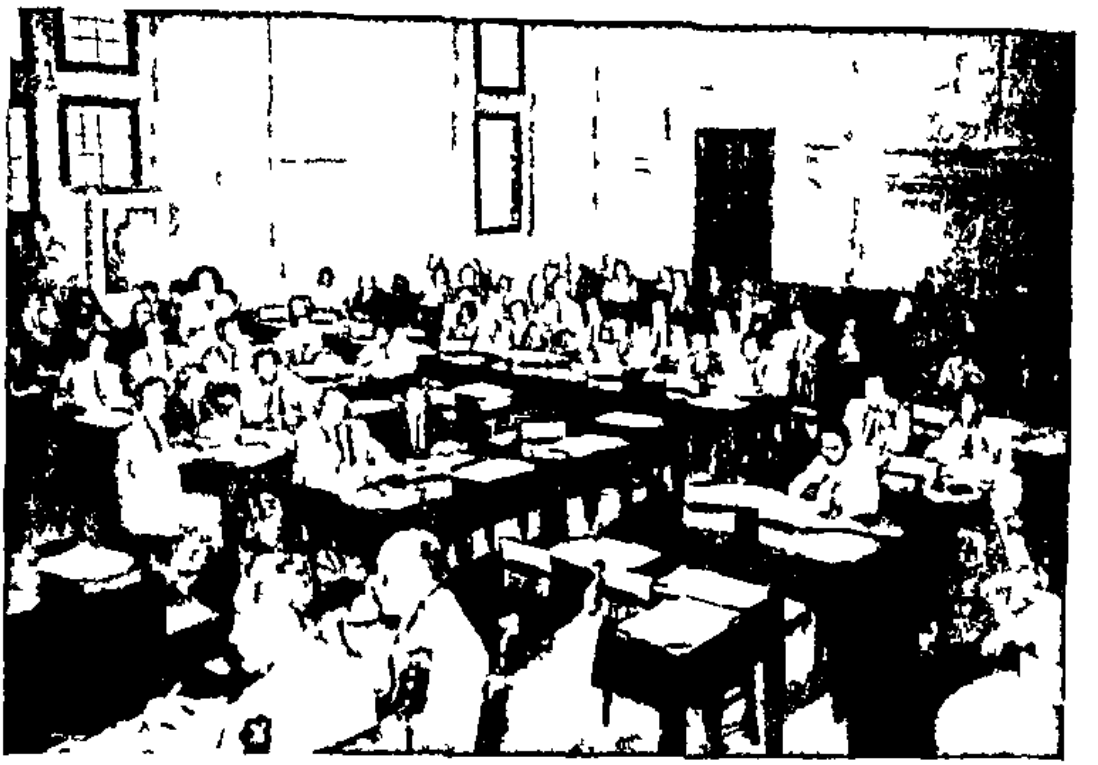


FIG 13 Second Health Assembly in plenary meeting

CO ORDINATION OF RESEARCH

Research is indispensable for the successful continuation of most of the health and medical projects undertaken and sponsored by WHO It is for this reason that not only has wide use been made of existing scientific institutes such as the Pasteur institutes in various towns the Haffkine Institute in Bombay the State Serum Institute in Copenhagen and the National Institute for Medical Research in London but existing research centres have been subsidized and new ones sponsored typical examples being the World Influenza Centre [40] and the International Salmonella Centre

Hitherto, however, although WHO has promoted and encouraged research no established policy or principles have been laid down the

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Constitution itself not being clear on this point On the proposal of the Indian delegation the Second Health Assembly defined more precisely the guiding principles which should be applied in the organization of research under the auspices of WHO

Research and its co-ordination are recognized as essential functions of the Organization but it was agreed that first priority should be given to research directly connected with or relating to the programme of WHO The use of existing institutes for research was confirmed research should be initiated in these or should form part of the duties of WHO field teams When started locally it should be so directed as to encourage the assumption by local agencies of responsibility for its continuation WHO should not at the present time consider the establishment under its own auspices of international research institutions

PUBLICATIONS

The importance of the publication programme in the work of WHO was stressed by several delegations and the programme proposed by the Director General was with a few minor exceptions adopted [41] This programme involves an output of approximately 15 000 printed pages during 1950 and includes the publication of the following periodicals [42] *Bulletin of the World Health Organi ation Chronicle of the World Health Organi ation International Digest of Health Legislation Weekly Epi demiological Record Epidemiological and Vital Statistics Report Official Records of the World Health Organi ation Weekly Fasciculus* of the Singapore Epidemiological Intelligence Station in addition to the *International Pharmacopoeia* (French and Spanish editions) the *Epidemiological Tele graphic Code* (Codepid) *Annual Epidemiological and Vital Statistics* an *International List of Treatment Centres for Venereal Diseases* statistical handbooks treatment and control manuals and supplements to the *Bulletin*

Discussion in the Committee on Programme was concerned chiefly with the *International Digest of Health Legislation* and the *International Health Yearbook* As to the former publication there was general agreement as to its usefulness It was felt however that as difficult problems of selection of material and of relative prominence were involved a report should be prepared so that the Third Health Assembly might study the methods of selection and presentation

The *International Health Yearbook* was intended as a continuance of the *Yearbook* formerly published by the Health Organization of the League of Nations and to provide an up-to-date description of the public health

[41] *Off R World Hl h Org* 18 1–8
[42] *Ch on World Hl h Org* 1948 2 189

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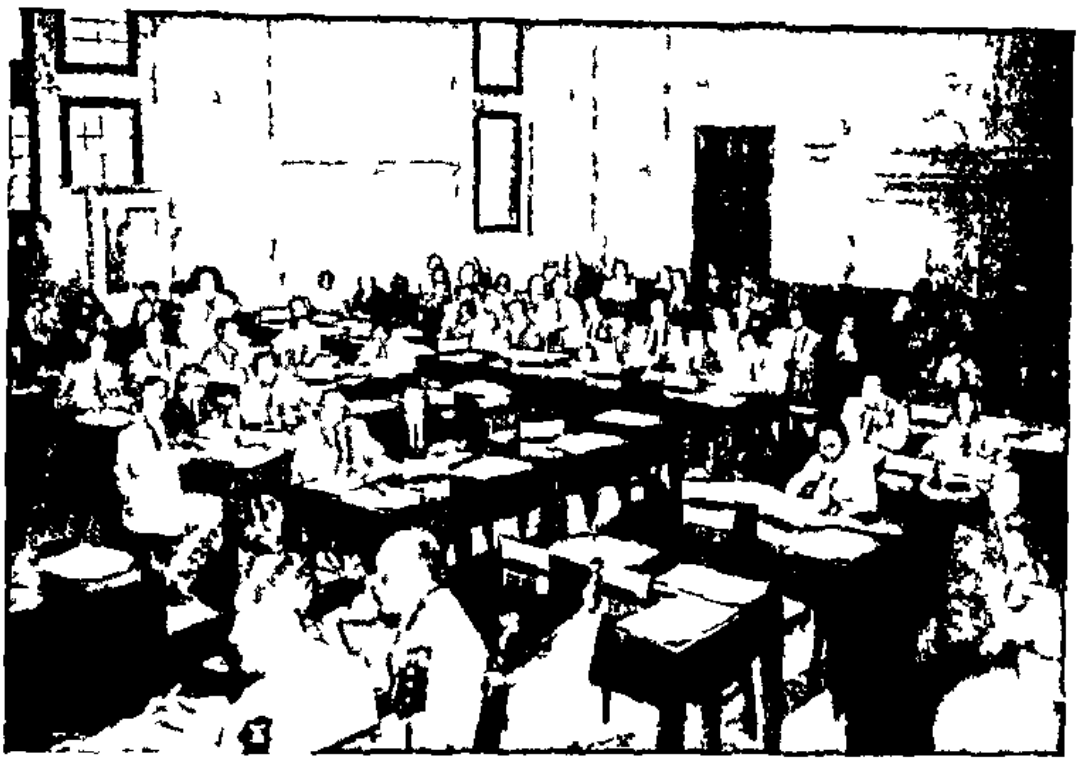


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Chron World Hlth Org 1949 3 1

HEALTH SITUATION OF DISPLACED PERSONS

On the proposal of the Greek delegation the Second Health Assembly adopted in a slightly amended form a resolution calling the attention of the Economic and Social Council to the disastrous consequences of the situation of displaced persons in different parts of the world and particularly to the health aspects of the problem and to the risk of epidemics in the respective regions The Health Assembly recommended an immediate examination of this question by the Economic and Social Council

OTHER ACTIVITIES

Other activities approved by the Second Health Assembly include

Continued support in collaboration with UNESCO of the Council for the Co-ordination of International Congresses of Medical Sciences This body which was established under the joint auspices of WHO and UNESCO will co-ordinate dates places and so far as is practicable main subjects of discussion and will assist in the technical organization of congresses it will also help them in the publishing of their proceedings [44]

Work done during 1948 1949 and its continuation during 1950 in biological standardization [45] unification of pharmacopoeias [46] and international control of habit forming drugs [47]

Establishment of an Expert Committee on Antibiotics and Technological Problems During 1949 WHO has already examined in conjunction with the Economic Commission for Europe (ECE) the economic aspects of the problem of penicillin production in Europe [48] The general aim of WHO is to make available to governments in co-operation with ECE, sources of technical knowledge on design installation and initial operation of the UNRRA penicillin plants [49]

Continuation of the World Influenza Centre [50] and of the International Salmonella Centre at Copenhagen taken over by WHO in 1949

Designation of regional brucellosis centres in the countries where the disease is prevalent [51]

Continued support in co-operation with UNESCO of the Interim Co-ordinating Committee on Medical and Biological Abstracting, whose function is to reduce the duplication of effort involved by the existence

[44] *Chron. World Hlth Org* 1949 3 106
[45] *Chron. World Hlth Org* 1948 2 188 1949 3 141
[46] *Chron. World Hlth Org* 1948 2, 43 1949 3 170
Chron World Hlth Org 1949 3 27
[48] *Chron World Hlth Org* 1949 3 53
Off R World Hlth Org 18 164
Chron. World Hlth Org 1949 3 12
Chron World Hlth Org 1949 3 75

organization of each country, either based on or reproducing in extenso the reports submitted by Member States under Article 61 of the WHO Constitution Some delegates thought that publication of the *Yearbook* in 1950 might be premature and after discussion it was agreed that the question should be referred to the Executive Board, for comment on the proper form content periodicity and usefulness of the *Yearbook* and that a report should be prepared for submission to the Third Health Assembly

WORLD HEALTH DAY

For practical reasons the Second Health Assembly changed the date of World Health Day from 22 July to 7 April

As the Constitution had originally been signed on 22 July, that had been considered an appropriate date It was later realized however, that schools and other places of education would at that time be closed, and could not therefore play a part in the observance of World Health Day, for which they should be important focal points

Hence the choice of 7 April the day on which the Constitution came into force in 1948

AID TO PALESTINE REFUGEES

The Director General had been authorized early in 1949 to take the necessary emergency measures in consultation with the Chairman of the Executive Board to deal with events requiring immediate action in connexion with the health situation of Palestine refugees As a result WHO made a contribution towards the improvement of sanitation of refugees and for preventive and medical services and has also conducted an investigation in the area [43]

As the health situation of the refugees in the Palestine area continues to cause anxiety and may if measures are relaxed, lead to epidemics which could be a threat to other countries, the Secretary General of the United Nations requested WHO to consider a substantially larger allocation for 1950 towards the medical care of the refugees The Health Assembly responded to this request and decided that insofar as the Organization s financial resources would allow, technical assistance should be rendered in 1950 through the United Nations as an emergency measure

Chron World Hlth Org 1949 3 67

ORGANIZATIONAL PROBLEMS

MEMBERSHIP

During the Health Assembly the State of Israel having accepted the Constitution and completed the necessary formalities was welcomed as a new Member of the Organization

Applications for membership by South Korea [53] and San Marino were discussed at some length by the Committee on Constitutional Matters It finally recommended although not unanimously the admission of South Korea In plenary session some delegations again opposed the recommendation but a proposal to delete it from the report was defeated on a roll-call vote and the report was adopted South Korea has however still to deposit the necessary instrument of acceptance of the Constitution

San Marino s application for membership was not accepted as it contained a reservation on the republic s financial contribution to the Organization

The action taken by the USSR Byelorussia and the Ukraine with regard to membership of the Organization was the subject of a resolution submitted to the plenary session by the Committee on Constitutional Matters It will be recalled that in February 1949 the Director General was notified by the respective Ministers of Health that these three States no longer considered themselves Members of the Organization The Executive Board after discussion decided to request the continued support of the three Members and to refer the matter to the Second Health Assembly [54]

The resolution adopted by the Health Assembly expressed deep regret at the absence of representatives of these three States from the Assembly and in the case of the USSR and Byelorus ia of members of the Executive Board Recognizing the consequent loss to the Organization s work it invited the three States to reconsider their intention

In the same resolution the Health Assembly approved the steps already taken in that regard by the Executive Board and the Director General and requested the Chairman of the Board and the Director General to continue endeavours to prevail upon the States to change their decision It also recommended that Member States should take such steps as they might deem suitable towards the same end

VACANT SEATS ON THE EXECUTIVE BOARD

The election of Members entitled to designate a person to serve on the Executive Board, which had proved a keenly-debated topic at the First

[53] See Resol on 195 III) 12 Decembe 1948 of th G ner l Assembly f th United N tions *Offi ial R ord f the thi d ssio f he G ne al Ass mbly* P rt I, pag 5

[54] *Ch on. World Hl h Org* 1949 3 56

of a number of abstracting services covering the same or overlapping fields [5]

Collection of further information on physical training with a view to submitting a programme to the Third World Health Assembly

Collection and dissemination of information on ways and means of health education as applied in various countries advice to governments, and assistance to countries in the production of their own educational material

[5] *Chron. World Hlth Org.* 1948, 2, 60



FIG. 14 Italian postage stamp issued in commemoration of the Second Health Assembly

Health Assembly [55] again evoked varied points of view One third of the 18 seats were due to be refilled the retiring members being those who had been designated by Australia Ceylon Iran Norway the United Kingdom and the United States of America

The President reminded the Assembly of two governing criteria under the relevant Article of the Constitution the election must take into account the need for an equitable geographical distribution among the membership of the Board and each of the countries elected must be able to designate a person technically qualified in the field of health" He pointed out further that the persons designated would not serve as representatives of their individual countries but would be trustees of the Health Assembly as a whole

In the ensuing discussion the claims of various groups of countries to have a member of the Board designated by one of their component States were presented to the Assembly Dr J N Togba (Liberia) suggested that, in view of the rapid pace at which the membership of the Organization was increasing the number of seats on the Board should be increased to facilitate an equitable geographical distribution The Director General however pointed out that such a proposal ran counter to a decision already taken by the Assembly which had agreed to preserve certain principles already laid down in the Constitution for elections to the Board

A vote on nine nominations before the Health Assembly was finally taken by secret ballot, and as a result the following six countries were elected to designate members of the Board the Philippine Republic Sweden Turkey the United Kingdom the United States of America and *Venezuela*

REGIONAL ORGANIZATION

A series of steps to facilitate the further development of WHO s regional structure was taken by the Second Health Assembly which had before it reports of the progress achieved in this sphere during the past twelve months

The First Health Assembly had provided for the regionalization of the Organization by demarcating six geographical areas—the Eastern Mediterranean Western Pacific South East Asia, European African and American —and had decided upon the early establishment of five regional organizations in addition to a special office for Europe [56]

The first of the regional organizations to come into being was that for South East Asia which began operations on 1 January 1949 [57] Shortly

[55] *Off R World Hl h O g* 13 8 *Chron. World Hl h Org* 1948 2, 167

[56] *Chron World Hl h Org* 1948 2 191

[57] *Chron. World Hl h Org* 1948 2, 2..5

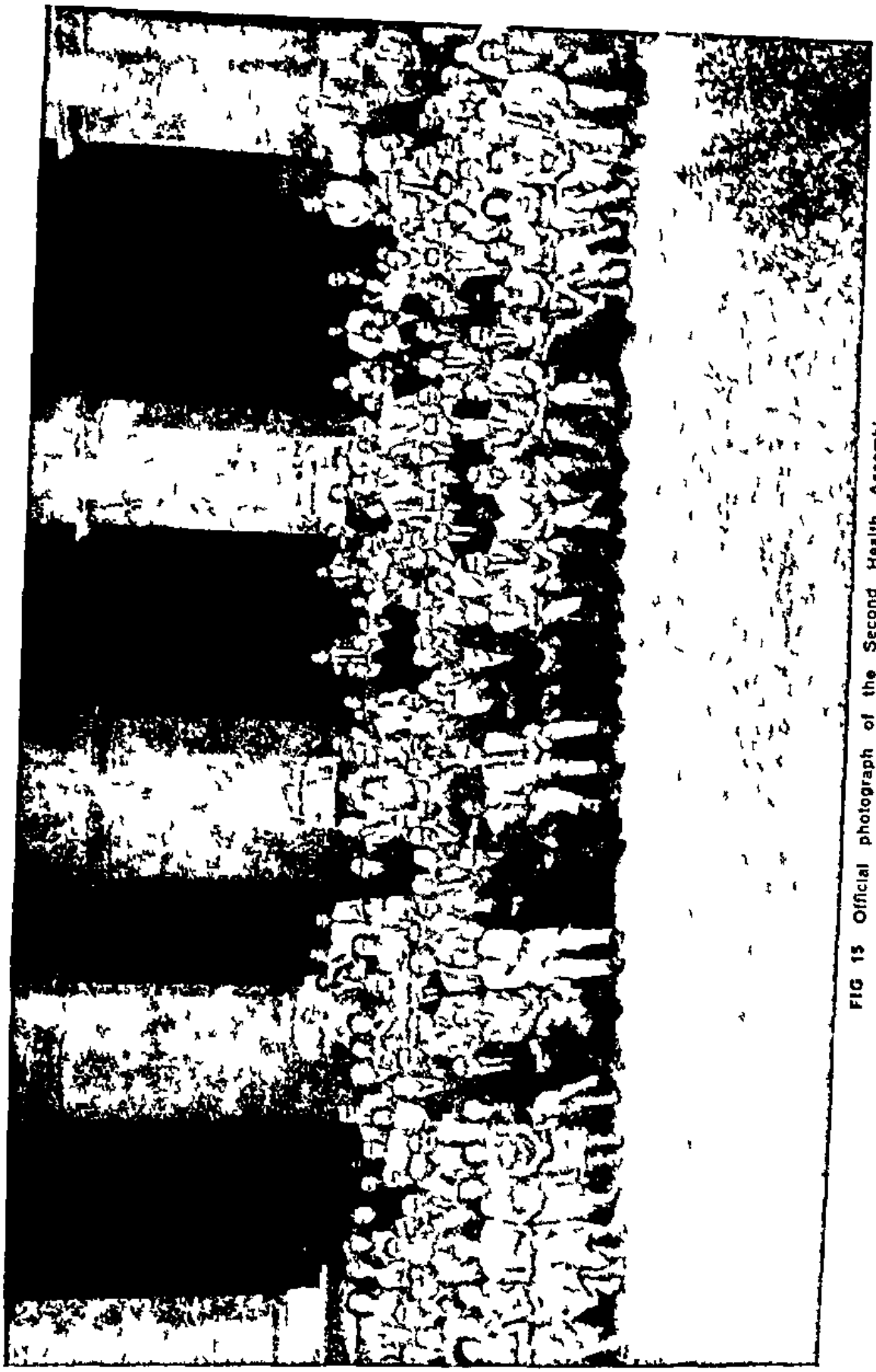


FIG 15 Official photograph of the Second Health Assembly

Africa

The proposed establishment of a regional organization for Africa had also been considered by the Executive Board One of the obstacles however to the realization of this plan was that the status of Member States Associate Members and other territories in the region and their respective rights and obligations had not been defined This difficulty has now been removed by the statement on this subject adopted by the Second Health Assembly

STATUS OF MEMBERS ASSOCIATE MEMBERS AND OTHER TERRITORIES

The status of States Members in a region and the rights and obligations of Associate Members and other territories were discussed by the Committee on Constitutional Matters [61] which drew a distinction between States Members having their seat of government in a region and those whose seat of government was elsewhere but which nevertheless considered certain territories within the region as part of their national territory or were responsible for the conduct of the international relations of territories within the region

The respective rights and obligations of these two categories of States Members formed the chief subject of debate Some delegations including those of the United Kingdom and the Netherlands were of the opinion that the administering powers should be represented on the regional committee together with the territories for which they are responsible other delegations such as those of Liberia and Ceylon felt that only those States Members having their seat of government within a given region should participate in the regional organization The delegation of the United States suggested that no fixed rule should be established and that different provisions should be adopted for each regional organization.

The resolution finally submitted to and adopted by the Health Assembly recommended the participation in the regional organization of the administering powers but limited them to one vote for all the territories or groups of territories in the region It also provided for the participation in regional committees of territories not responsible for the conduct of their international relations and defined their voting rights They will have all rights and obligations except that they will have no vote in plenary meetings of the regional committee nor in sub-divisions dealing with finance or constitutional matters In the case of those which are not Associate Members the application of this principle will be subject to consultation between the States Members in a region and the Members or other authority responsible for the international relations of these territories

[61] The report on this committee together with the resolution adopted will be published in *Off Rec World Hlth Org* 21

afterwards the Executive Board approved the establishment of the Regional Office for the Eastern Mediterranean Area [58]

Concurrently arrangements were proceeding for the Pan American Sanitary Bureau to act as the regional office for the Americas A temporary working arrangement was followed by an agreement signed at Washington on 24 May 1949 between Dr Brock Chisholm the Director General of WHO and Dr F L Soper Director of the Bureau [59] The agreement duly endorsed by the Second Health Assembly is effective as from 1 July 1949

Europe

Earlier this year the Executive Board approved a proposal by the Government of Czechoslovakia for the establishment of a regional organization for Europe [60] In authorizing the Board to establish the regional organization as soon as the consent of the majority of Member States in the European Area had been obtained, the Health Assembly noted that the special office for Europe—set up on 1 January 1949—would automatically be dissolved upon the establishment of a regional office

A request by the Greek Government for the inclusion of Greece in the European Area was approved by the Assembly At the First Health Assembly the Greek delegation had reserved its position on a proposal that the country should be part of the Eastern Mediterranean Area

Western Pacific

The Committee on Constitutional Matters discussed a proposal by the delegation of the Philippine Republic for the establishment of a regional organization for the Western Pacific Area It was pointed out however that for a variety of reasons it would be difficult at present to obtain the necessary agreement to such a step from the majority of the Member States in the region Factors in the situation were the civil war in China the unsettled state of some other countries and the fact that Japan was still under occupation Furthermore the delegations of Australia and New Zealand could give no undertaking that their governments would participate in a regional organization for the Western Pacific Area although these countries were prepared to co operate in other ways in common health problems of the area The committee noted the proposal and a resolution to this effect was endorsed by the Health Assembly

Chron World Hlth Org 1949 3 13
Chron World Hlth Org 1949 3 131
Off Rec World Hlth Org 17 16

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SCALE OF ASSESSMENTS

Among the matters discussed by the Committee on Administration and Finance was the scale to be used in assessing the contributions of Member States to WHO

The starting point of the debate was a resolution by the Executive Board putting forward the principle that no one Member State should contribute more than one third to the regular expenses of the Organization for any year [6]

The problem was one which had already given rise to differences of opinion at the First Health Assembly where the United States delegation dissented from a decision establishing a scale under which that country was assessed at 4 787 units out of a total of 12 612 for all States at that time Members of WHO

At the Second Health Assembly Dr L A Scheele (United States of America) quoted figures of United States foreign assistance as evidence of the large share his country was bearing in international programmes

The Health Assembly s resolution on the point recognized that it was in the best interests of WHO that no one Member State should contribute more than one third to the regular expenses of the Organization for any year provided that the per capita contribution of any Member State shall not exceed the per capita contribution of the Member paying the highest contribution

This principle is to be made effective as world economic conditions improve in gradual stages starting in 1950 The scale of assessments will be based on that for 1948 and 1949 with appropriate adjustments to establish the 1950 contribution of the USA at 36% of the total

RELATIONS WITH SPECIALIZED AGENCIES

The Second Health Assembly expressed its satisfaction with the work of WHO during the past year in its relations with the specialized agencies of the United Nations and requested that full co operation should be continued

Some of the most important projects of WHO are carried out in close co operation with other specialized agencies particularly FAO ILO UNESCO and UNICEF, and with the United Nations itself and continued collaboration with these organizations is of the greatest importance for WHO

WHO HEADQUARTERS BUILDING

The increase in the staff of the Organization during the last year has presented a serious problem of accommodation at the Headquarters office

[6] *Off Rec World Hlth Org* 17 20

in the Palais des Nations Geneva and a number of possible solutions was submitted to the Second Health Assembly It was felt however that the various projects had not yet been worked out in sufficient detail for a choice to be made at the present time The Health Assembly therefore gave certain directives on the subject but delegated the taking of the final decision to the Executive Board acting in conjunction with the Director General at the same time requesting the Board to begin building operations as soon as possible

THIRD WORLD HEALTH ASSEMBLY

The Third World Health Assembly will open in Geneva Switzerland at the headquarters of the Organization on 8 May 1950

izations governmental and non governmental inside the country itself The committee has already shown its great practical importance and I am bold enough to ask whether perhaps there might not also be reason for other countries to appoint similar committees

Dr E. Clavcaux Uruguay

I feel that this Organization should not try to assume the responsibilities which belong to governments It must not invade fields which are recognized to be the activity of private charitable organizations It must not try to assume functions which are proper to the universities It can and must however draw on established science on goodwill and on reliable statistics in order to direct its activities in the threefold interest of governments peoples and technicians as precisely as possible so as to achieve its objectives without becoming involved in extraneous issues

Dr A Stampar, Yugoslavia

It is self-evident however that the knowledge of highly specialized experts should be available all over the world and it is a duty of WHO to do all in its power to organize this But its foremost duty is I think to help the national health administrations to promote special knowledge and to make it possible for their experts to acquaint themselves with the latest achievements in their specialities I should say that it is rather rare for foreign specialists of exceptional qualities to be used very profitably The number of foreigners who are able to assess correctly the internal conditions of countries which are new to them is small especially if they stay there only for a short time or if they come with certain prejudices They lose much time in adapting themselves and very often they do not succeed

Our Organization will be much more successful if in the coming years it concentrates on strengthening the national and regional health organizations particularly in the promotion of specialization of medical personnel and other technicians by sending them to those countries where they can learn most

Rajkumari Amrit Kaur India

The fellowship scheme is a valuable feature of our work and should be continued I would however point out that the knowledge gained by students abroad is very often difficult to put into practice under local conditions at home Therefore while reserving fellowships for the senior technical workers we must concentrate on the strengthening of national health institutions by the loan of foreign experts for short periods in order that the bulk of the national health staff may receive proper training in their own environment and under their peculiar local conditions Suitable understudies must of course be provided by national governments

Dr M Mackenzie United Kingdom

His Majesty s Government congratulates the World Health Organization on its boldness in undertaking work in so many new fields of international collaboration such as regional organization the adoption of the principle of associate membership the establishment of centres for the study of various diseases such as influenza the potentialities of health demonstration areas the importance of mental health in the social structure the implications of the new discoveries in connexion with insecticides collaboration with non governmental organizations the co-ordination of international congresses and the newer developments in bibliographical abstracting

Dr L. F Thomen Dominican Republic

However I think it proper again to call attention to the fact that the problems vary in importance according to the conditions of the various geographical zones While in some regions very advanced plans will be advisable in others it will be necessary to concentrate particularly on basic sanitary problems

Dr A Khaum Austria

The confusion in health matters caused by the German occupation of Austria will have to be overcome and many laws decrees and orders of the Ministers of the

German Reich which had been in force in Austria as well as Austrian health laws will have to be replaced by clear precise and modern regulations These aims have not yet, it is true been achieved but the results obtained so far are remarkable The Austrian Parliament has now passed 14 laws which have already been published and approved a number of legal regulations on health matters Furthermore 22 decrees have been promulgated Of this legislation I would like to mention only the following examples a modern law dealing with narcotics which satisfies all the requirements of the existing conventions on dangerous drugs new laws on vaccination against smallpox and also inoculation against tuberculosis redrafting of the law relating to epidemics new and up-to-date regulations dealing with nurses and dentists a recently published law on medical practitioners which not only regulates the practice of the medical profession but deals with the co-operation of the faculty through their own representatives in all health questions

The work of the Austrian health authorities in simplifying and unifying health legislation will be continued and developed so as to promote the co-ordination of such legislation throughout the civilized world Austria is of opinion that a most praiseworthy task of WHO would be the setting up of a committee of experts to co-ordinate modernize and simplify all health legislation and regulations Austria would be happy to be able not only to accept the benefits of WHO but also to collaborate with the Organization and to help it to achieve its aims

Mr J Plojhar Czechoslovakia

It is more urgent for us to dispose of some public health problems than to receive good advice What is more if we are to make practical use of this advice certain material pre-conditions must be fulfilled The teaching of basic subjects such as biology biochemistry and biophysics must be developed and we must also introduce the study of modern anaesthesiology in our universities Our specialists must learn the modern methods in medicine that are being applied in the international field Mere advice is not enough for this purpose We require also in order to carry out this programme to be in possession of the necessary apparatus and to obtain animals The means of production [of penicillin] require to be modernized and we must therefore obtain the necessary apparatus that exists abroad It should be one of the tasks of the World Health Organization to facilitate the delivery of such apparatus to us

Dr Irène Domanska, Poland

But what do these principles look like when put into practice ? We have taken the liberty of quoting a few examples drawn from a country of the importance of the United States The Medical Research Committee has been unable to publish some of [its] results or has only published them in incomplete form or after very great delay since the policy followed during the war is still being pursued The whole world ought to be able to take advantage of the benefits of science Such an attitude has therefore caused anxiety amongst American scientists and politicians Unfortunately for military and industrial reasons the principle of the curtailment of the liberty to exchange information and literature has won the day

The scientific and popular American press frequently dwells on the constructive nature of the results obtained in the Biological Weapon Research Centre at Camp Detrick

5 000 specialists were studying medical problems at this centre The most elementary humanitarian principles should have led to the publication of the results of their researches However all the discoveries were first exploited by the chemical industry Thus instead of serving the interests of peace and the welfare of humanity scientific discovery came into the hands of trade The methods of production of chemical medicaments whose value if the experts are to be believed exceeds the bounds of medicine and enters the realm of world economy (for example

in connexion with the disinfection of areas subject to sleeping sickness) and even of demography should not remain secret seeing that the modern production of these medicaments depends to a great extent upon technical operations which are quite as important as the principles of production themselves Unfortunately technological processes are not made public either in review or through direct news bulletins The American pharmaceutical factories permit probationers and holders of fellowships to visit the scientific research or testing laboratories but never give any hints about the production of the medicaments It is unnecessary to stress the significance and the humanitarian scope of a drug like streptomycin which for the first time in history has made it possible to deal with ailments such as tuberculous meningitis The production of this drug is still not only insufficient to cover medical needs in general but even the needs of paediatricians in the campaign against tuberculosis in children In spite of this nothing has been done to make a beginning with production outside the United States and it is perhaps better to say no more on the subject The information so far published on the chemical properties and composition of the new antibiotic aureomycin is extremely scanty The same can be said of chloromycetin Farrington Daniels Director of the Metallurgical Laboratory of Chicago University put the position in this field admirably when he said that hundreds of scientists have worked enthusiastically for years without being able to publish the results of their labours either in reviews or in monographs

Owing to the political atmosphere in the United States American scientists are reluctant to receive holders of fellowships from the popular democracies since their admission might be considered an anti American activity When they are admitted these Fellows find great difficulty in obtaining information WHO can do nothing to remedy this state of affairs and the sending of Fellows under such conditions is often useless owing to the unjust and unwarranted policy of the majority of the Executive Board as well as of the Secretariat and Administration the USSR Byelorussia and the Ukraine have left WHO declaring that collaboration with it had become useless as WHO had not fulfilled its task and had failed in its mission

Mr J Plojhar Czechoslovakia

I must unfortunately state that the World Health Organization is in the throes of ideological conflicts It is being drawn into using its influence on behalf of one of these ideologies I should like to put you on your guard against the dangers of such a policy which might result in a split or even the complete dissolution of this world institution which can only do effective work if it holds aloof from all conflicts if it is supported by all countries and if it takes into account the importance of the special needs of the various countries

Dr L A Scheele United States of America

I agree fully that the World Health Organization and this Assembly should not become an arena for political discussion or activity It has been said that the refusal of export licences for certain apparatus has jeopardized human life I wish to deny this charge on behalf of the Government of the United States A specific piece of equipment has been mentioned It was implied that this equipment is necessary in the production of penicillin This is not the case The highest grade crystalline penicillin can be produced and is being produced commercially today in the United States without this equipment A specific charge has been made therefore which cannot be substantiated

The statement has also been made that the United States has refused to help children suffering from malnutrition caused by the war I do not understand this statement in view of the large role the United States has played through UNRRA in the past and at this very moment through the International Children s Emergency Fund and much private effort Through these agencies the American people have rendered great assistance in

the nourishment of children of many countries

Dr A. H Radji Iran

The decentralization of WHO through the establishment of regional committees is a wise move provided that this does not mean breaking up the World Health Organization into six small worlds We should not slip back into becoming regionally minded but we must always remember the global aspect of health There is a serious need for continued co-ordination of policy planning and overall direction There must be a clear definition of the functions and limitations of regional offices or chaos will result

In Iran we are embarking on a tremendous seven year programme of development of which the health section is an impressive part Parliament has already voted approval Malaria is our number one problem standing as it does in the way of both health and economic advance Already a serious programme of control on a modest scale is in operation with plans being made for a nation wide attack in 1950 We are deeply grateful to WHO for help already begun or planned and our testimony is that this is a live productive organization destined to have a great and lasting effect on the health of the world

Dr F U Kazi Pakistan

In our concept of future planning, therefore we must be guided more and more by the precise knowl dge obtained through our regional organizations which alone are best fitted to study the prevailing problems and to suggest appropriate remed es The central Secretariat should concern itself with presenting a composite picture of the o erall situation secured through thes sources thereby furnishing the Organization with a safe and sound basis for acti ities We realize that this procedure may entail a certain amount of delay which may tax our patience particularly when we see such misery around us But in spite of th s we would commend this policy for in the affa rs of mankind in general and of health in particular it does not always happen that the seemingly shortest is the nearest route to our goal

Dr I Simonovits, Hungary

Now the Hungarian people have found what peaceful rebuilding means During the four years since the liberation we have rebuilt completely our health service system Having rehabilitated 24 000 hospital beds today we dispose again of 50 000 hospital b ds At the end of the five year plan to be started next year we shall have 60 000 available hospital beds As a result of the reconstruction we now have 38 tuberculosis and 40 venereal disease dispensaries more than b fore the war In 1944 we had 57 mat rnity homes at the end of this year there should be nearly twice as many

The result of these four peaceful years of reconstruction work is that in Hungary the health service is much better than at any time before the war For instance infant mortality has declined from 13 1 % to 9 6 % in Budapest to 6 6

Dr M Mackenzie United Kingdom

The great possibilities of health work in the international field in themselves constitute a danger that of attempting to cover too much ground superficially Outside pressure to obtain results rapidly and the desire to justify the existence of the Organization in lay circles may well be contributory factors to unsatisfactory and shallow work

Dr A Stampar Yugoslavia

I think you will agree with m that in fact positive medicin in reality rests on four main principles social and economic security education nutrition and housing It might well be that our Organization should pay the greatest attention to these principles and to h lping to promote these iews all over the world I should like particularly to stress the question of education not only of the whol people but especially of thos p rsons to whom mankind has *entrusted th care of its* health Are we not vet fully conscious that we must put forward a n w typ of

in connexion with the disinfection of areas subject to sleeping sickness) and even of demography should not remain secret seeing that the modern production of these medicaments depends to a great extent upon technical operations which are quite as important as the principles of production themselves Unfortunately technological processes are not made public either in review or through direct news bulletins The American pharmaceutical factories permit probationers and holders of fellowships to visit the scientific research or testing laboratories but never give any hints about the production of the medicaments It is unnecessary to stress the significance and the humanitarian *scope of a drug like streptomycin which* for the first time in history has made it possible to deal with ailments such as *tuberculous meningitis* The production of this drug is still not only insufficient to cover medical needs in general but *even the needs of paediatricians in the* campaign against tuberculosis in children In spite of this nothing has been done to *make a beginning with production outside* the United States and it is perhaps better to say no more on the subject The information so far published on the chemical properties and composition of the new antibiotic aureomycin is extremely scanty The same can be said of chloromycetin Farrington Daniels Director of the Metallurgical Laboratory of Chicago University put the position in this field admirably when he said that hundreds of scientists have worked enthusiastically for years without being able to publish the results of their labours either in reviews or in monographs

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Mr J Plojhar Czechoslovakia

I must unfortunately state that the World Health Organization is in the throes of ideological conflicts It is *being drawn* into using its influence on behalf of one of these ideologies I should like to put you on your guard against the dangers of such a policy which might result in a split or even the complete dissolution of this world institution which can only do effective work if it holds aloof from all conflicts if it is supported by all countries and if it takes into account the importance of the special needs of the various countries

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DELEGATIONS AND OBSERVERS PARTICIPATING IN THE SECOND HEALTH ASSEMBLY

MEMBER STATES

Afghanistan

Delegates

Dr G Farouk Deputy Minister for Public Health (*Chief Delegate*)
Dr A Zahir Director-General Kabul Municipal Hospitals

Albania

Delegates

Dr S Klosi Inspector-General Ministry of Public Health (*Chief Delegate*)
Mr F Kota Assistant Chief Department for International Organizations Ministry of Foreign Affairs

Argentina

Delegate

Dr A A Pozzo Director of Technical Education and Scientific Research Ministry of Public Health

Australia

Delegates

Dr H E Downes Assistant Director-General of Health (*Chief Delegate*)
Dr D A Dowling Chief Medical Officer Australia House London
Mr J Plimsoll Department of External Affairs

Alternate

Mr J R Rowland Department of External Affairs

Austria

Delegates

Dr A Khaum Director of Public Health (*Chief Delegate*)
Dr F Puntigam Counsellor Ministry of Social Welfare
Mr K Strobl Counsellor Ministry of Social Welfare

Belgium

Delegates

Professeur M de Laet, Secrétaire géneral du Ministère de la Sante publique et de la Famille (*Chief Delegate*)
Dr A N Duren Conseiller medical au Ministère des Colonies
M L A D Geeraerts Directeur au Ministère des Affaires étrangeres et du Commerce exterieur

Alternates

Baron C van der Bruggen Attache au Cabinet du Ministre de la Sante publique et de la Famille
Dr P J J van de Calseyde Directeur general de l Hygiène Ministère de la Santé publique et de la Famille
Dr J F Goossens Directeur general au Ministère de la Sante publique et de la Famille
Professeur J A H Rodhain Conseiller medical au Ministère des Colonies

physician who would from the ideological and technical point of view be differently educated from those at present training in most institutions for medical education ? Would it not be useful if our Organization collected as much information as possible on this matter and if it convened a conference at which these questions concerning education could be fully discussed and at which recommendations could be passed which would in my opinion be very useful to all Members ?

Dr A R Dujarric de la Rivière France

We have just passed days which will remain in our memory in the splendid setting of the Eternal City where there is so much to appeal to the spirit and touch the heart We have greatly appreciated all the ceremonies to which the Italian Government and delegation have so kindly invited us and which they have organized with that generosity of feeling and greatness of heart which are essential characteristics of the Italian soul and for which we tender our most sincere and warmest thanks But we have also appreciated perhaps still more the chance which has been given us of studying here questions of a medico social nature which we found of the greatest interest

A health organization which has few equals anywhere in the world where all manner of medico-social questions are studied magnificently organized labor atories in which great scientists study questions involving the health of humanity the fight against tuberculosis and above all (to cite only this example) the campaign against malaria which may truly stand as an example to the world—these are the things which the Italian Government and our Italian colleagues have allowed us to see and we can never be sufficiently grateful to them

Dr K Evang Norway

Statesmen and economists all over the world seem to realize the close relation between health and economy health and social conditions health and the standard of living Through the specialized agencies of the United Nations the peoples of the world have for the first time in history created organizations for a practical co-ordinated approach to these problems Much hope therefore is attached to the resolution passed by the Economic and Social Council in this respect, and also to the initiative which preceded it On the whole the Second World Health Assembly has clearly emphasized that our greatest and most urgent problems are to be found in underdeveloped areas At the same time we must not forget the necessity of giving those countries which have proved their ability to do so an opportunity to experiment and to develop further effective modern methods for promoting health and fighting disease These progressive countries are our pilots and they also need our continued support

Czechoslovakia

Delegates

Mr J Plojhar Minister of Health (*Chief Delegate*)

Dr B Schober Head Department of Foreign Relations Ministry of Health (*Deputy Chief Delegate*)

Dr I Gonda Chief Tuberculosis Control Division Department of Public Health, Slovakia

Denmark

Delegates

Dr J Frandsen Director General National Health Service (*Chief Delegate*)

Dr O Andersen Professor University of Copenhagen

Dr J H Holm Chief Tuberculosis Division State Serum Institute Copenhagen

Advisers

Dr A C Clemmesen Chairman Danish Medical Association

Mr B Sørensen *Chief of Section Ministry of the Interior*

Dominican Republic

Delegate

Dr L F Thomen Ambassador Extraordinary and Plenipotentiary to the United States of America

Egypt

Delegates

Dr N Scander Pasha Minister of Public Health (*Chief Delegate*)

Dr M Nazif Bey Assistant Under Secretary of State Ministry of Public Health

Sir Aly Tewfik Shousha Pasha Under Secretary of State Ministry of Public Health

Adviser

Dr M Abdel Azim Bey Director General Rural Health Department

El Salvador

Delegate

Dr J Allwood Paredes Director General of Public Health

Ethiopia

Delegate

Mr A Retta Envoy Extraordinary and Minister Plenipotentiary to the United Kingdom

Adviser

Dr F B Hylander Inspector General Ministry of Public Health

Finland

Delegates

Mr H Holma Envoy Extraordinary and Minister Plenipotentiary to Italy

Professor S Savonen Member of the State Medical Board

France

Delegates

M P Schneiter Ministre de la Santé publique et de la Population (*Chief Delegate*)

Dr A R Dujarric de la Rivière Sous Directeur de l Institut Pasteur Paris

Médecin-Général Inspecteur M A Vaucel Directeur du Service de Santé colonial Ministère de la France d Outre Mer

Brazil

Delegates

Dr H P Fróes Director National Department of Health (*Chief Delegate*)

Dr G H de Paula Souza Director and Professor Faculty of Hygiene and Public Health University of São Paulo (*Deputy Chief Delegate*)

Dr R Santos Professor of Hygiene and Public Health Faculty of Medicine Bahia

Advisers

Dr F Affonso Costa Director Division of Social Welfare National Department of Child Welfare

Dr O Lopes da Costa Assistant to the Director General National Department of Health

Mr I P Marinho Consul of Brazil Rome

Bulgaria

Delegates

Dr P Tagaroff Minister Plenipotentiary to Italy (*Chief Delegate*)

Dr S Stoyanoff Chief Assistant Faculty of Medicine Sofia

Adviser

Dr V Petrov Mevorach Press Attaché Bulgarian Legation Rome

Burma

Delegate

Dr Ba Maung Port Health Officer Rangoon

Canada

Delegate

Dr G D W Cameron Deputy Minister of National Health Department of National Health and Welfare

Alternates

Dr J Grégoire Deputy Minister of Health Province of Quebec

Dr J E Plunkett Honorary Secretary Treasurer Royal College of Physicians and Surgeons of Canada Ottawa

Advisers

Mr J G H Halstead Foreign Service Officer Office of the High Commissioner for Canada London

Dr A M Savoie Immigration Medical Officer Rome

Ceylon

Delegates

Mr S W R D Bandaranaike Minister of Health and Local Government (*Chief Delegate*)

Dr S Rajendram Superintendent Antimalaria Campaigns

Dr W G Wickremesinghe Acting Director of Medical and Sanitary Services

Chile

Delegate

Dr P Martinez Deputy Director General of Public Health

Costa Rica

Delegates

Mr E Steinvorth Consul of Costa Rica Geneva (*Chief Delegate*)

Dr M C Perez

Dr O Steinvorth

Iraq

Delegates

Dr S El Zahawi Director Pathological Institute Baghdad (*Chief Delegate*)
Dr S Al Wahbi Director Kirkh Hospital Baghdad
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[63] See Resolution 195 (III) 12 December 1949 of the General Assembly of the United Nations *Official Records of the third session of the General Assembly* Part I page 25

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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

FOURTH SESSION OF THE EXECUTIVE BOARD

Measures aiming to ensure the optimum efficiency of the World Health Organization and to facilitate the work of the next World Health Assembly in its consideration of the programme and budget for 1951 were among those on which decisions were taken by the Executive Board at its fourth session held in Geneva from 8 to 19 July 1949 [1]

While much of the session was devoted to administrative and budgetary matters the Board also took a number of decisions on questions of wider significance Into the latter category fall the projected establishment of a system of common nomenclature for drugs sold internationally participation in the development of co ordinated planning to promote the health and welfare of children a project for UNICEF/WHO assistance in the establishment by the French Government of a children s centre in Paris and plans for combating the threat to health due to the spread of venereal infections by boat traffic in the Rhine area

Fifteen members seven of them new attended the session The fact that one of the new members Professor de Laet a Belgian had been designated by a country (the Netherlands) of which he is not a national provided an interesting illustration of the principle that members sit on the Board as representatives of the Health Assembly as a whole and not of their individual countries

Sir Arcot L Mudaliar was elected Chairman in succession to Sir Aly Tewfik Shousha Pasha who has been appointed Director of the WHO Regional Office for the Eastern Mediterranean Dr J Zozaya and Dr H S Gear were elected Vice Chairmen

Observers were sent by the United Nations the Economic Commission for Europe (ECE) the International Labour Organization (ILO) the

[1] The final report of the fourth session of the Executive Board will be published *Off R World Hlth Org* 22 For list of members see p 245

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Note — The *Chronicle of the World Health Organization* is published monthly in English French Spanish Chinese and Russian The *Chronicle* reports the activities of the Organization without however claiming to be an authoritative record of its official views which are set out in the *Official Records of the World Health Organization* All correspondence relating to it should be addressed to the World Health Organization Palais des Nations Geneva Those who may wish to reproduce the text of the *Chronicle* or extracts therefrom more especially in the medical Press are entirely at liberty to do so

The immediate programme would have as its basis much of the work already undertaken by UNICEF and would include the following activities

(*a*) training courses in child care and child development for physicians nurses social workers and administrators

(*b*) such laboratory research on BCG or similar subjects related to children as WHO may desire to have carried out under its direction

(*c*) investigations in child nutrition including experimental demonstrations carried out under policies developed by and with the technical advice of WHO FAO and UNICEF

(*d*) studies of the health educational and social problems of children suffering from the effects of war carried out under policies developed by and with the technical advice of the United Nations UNESCO WHO and UNICEF

The decision of the Executive Board envisages assistance by WHO for a period of not more than three years The Organization could give assistance of the following types

(*a*) group or individual international fellowships to physicians nurses medical and psychiatric social workers maternal and child health administrators hospital administrators hospital architects etc to study various aspects of child health and welfare and social paediatrics

(*b*) facilitating special international group fellowships for teams of health and welfare workers engaged in meeting special needs of children as for example the team of doctor nurse physical therapist psychologist social worker etc who together work to restore and rehabilitate crippled or otherwise handicapped children or teams of doctor and nurse to study the care of premature infants

(*c*) provision of experts to assist in teaching and research activities

(*d*) advice of expert committees

(*e*) advisory service on organization of demonstration child health programmes to serve as field experience centres

Anti Venereal Disease Commission of the Rhine

The part to be played by WHO in the co ordination of venereal-disease control in the Rhine area was discussed by the Board on the basis of the report and recommendations of the preparatory meeting on the subject held from 30 May to 1 June 1949 in Geneva [4] At that meeting attended by representatives of Belgium France Germany the Netherlands and Switzerland a programme was discussed for the establishment of a commission In authorizing the necessary assistance to the countries concerned

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The ad hoc committee would explore and recommend ways and means of focusing the attention of the United Nations on the needs of children through joint action with the specialized agencies of determining the needs of children on a current and continuing basis and of meeting them through national and international action The development of co ordinated planning to ensure a maximum effort by specialized agencies toward assisting governments in their programmes on behalf of children would be studied and the committee would also consider ways of stimulating national and international research involving sociological psychological educational anthropological and medical approaches It would report on its conclusions with specific recommendations on the above mentioned points and on the means whereby a continuing interagency mechanism might be provided for their accomplishment

FIG 2 SIR ARCOT L MUDALIAR
CHAIRMAN OF THE EXECUTIVE BOARD



International Children's Centre

Closely allied to the foregoing decision is one approved in principle by the Board, that WHO should assist jointly with UNICEF in the establishment by the French Government of a children s centre in Paris The centre would be used for research and training by UNICEF the United Nations organizations specially concerned with child welfare and governments It would be administered by the French Government and would open to workers in child health and welfare the possibility of a first class technical and medical training adapted to the needs of the various countries thereby meeting a need which has become in recent years increasingly insistent

lethal doses (m l d) laid down for the satisfactory immunization of man in the standards for the manufacture and control of yellow fever vaccine but an excess which is recommended in those standards [7] All members of the Yellow Fever Panel of WHO concerned with the laboratory eva luation of yellow fever vaccine to whom the results were communicated considered the vaccine to be in every way suitable for international use and recommended its approval by WHO

Epidemiological Broadcasts

Owing to the favourable response of health administrations to the daily service of epidemiological broadcasts from Geneva which were begun last January on a trial basis [8] the Board placed this system on a permanent basis

The Board was informed that reception generally had been good except in the central part of South America and in central Africa To remedy these defects arrangements had been made with the Brazilian and French Governments for the relay of the broadcasts

Regional Organization for Europe

The Second Health Assembly had authorized the Board to establish a regional organization for Europe as soon as the consent of the majority of Member States in Europe had been obtained [9]

The Board authorized the Director General to establish the regional organization on fulfilment of the necessary conditions and took other decisions providing for the expeditious establishment of the site and the appointment of the regional director

Deontology Establishment of an International Code

The Board expressed satisfaction with the steps taken by the World Medical Association with a view to the establishment of an international code of deontology in connexion with the practice of medicine It asked the Director General to keep in close touch with this work and to bring the matter to the attention of the International Council of Nurses

The final draft of the code as submitted by the Executive Board of the World Medical Association to 40 national medical associations will be considered in October by the Annual General Assembly of the World Medical Association

A further report will be submitted to the next session of the Executive Board

See *Epidem Inform B II* 1945 1 365
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the Board made it clear that the body envisaged was not an expert committee nor a regional committee, but a special local commission to co ordinate venereal-disease measures among countries bordering the Rhine

Malaria Scope of the Expert Committee

The Second Health Assembly had referred to the Executive Board a proposal by the Italian delegation for the transformation of the Expert Committee on Malaria into an expert committee on malaria and other insect borne diseases [5] In the discussion on this proposal some members of the Board feared that the expert nature of the existing committee would be impaired if the consideration of all insect borne diseases were brought within its scope

The Board finally endorsed Dr M Mackenzie s view that it was not desirable at the present time to make the proposed change in the committee

Tuberculosis Officers and Consultants

In a paper submitted to the Second Health Assembly the delegations of Czechoslovakia Denmark Finland and India had suggested inter alia that the services of the temporary consultants in tuberculosis should be limited to a minimum and that a full time WHO tuberculosis officer should be employed in each regional office [6]

The proposal had led to an interesting discussion in the Committee on Programme on the relative emphasis to be placed on temporary consultants as against full time regional staff officers, the question being finally referred to the Executive Board

The view of the Board was that the matter was one which could be decided by the Director General in each instance in the light of the individual circumstances It referred to him for his consideration in developing the programme for advisory demonstration services to governments the relevant recommendations contained in the note submitted to the Health Assembly by the delegations concerned

Approval of the Institut Pasteur Yellow Fever Vaccine

The Board approved for international use the yellow fever vaccine produced by the Institut Pasteur Paris On application to WHO by the Director of the Institut Pasteur the vaccine had been tested by three recognized control laboratories in accordance with the required procedure in such cases The results of potency titration showed that the vaccine in its recommended dosage had a content much in excess of the 500 minimum

[5] *Chron World Hlth Org* 1949 3 186
[6] *Chron World Hlth Org* 1949 3 190

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Dr V. J. Babecki, Inspector, Ministry of Health, Warsaw (Poland)

Dr H. S. Gear, Deputy Chief Health Officer for the Union of South Africa, Cape Town (Union of South Africa) (*Vice-Chairman*)

Dr J. A. Hojer, Director General of Public Health, Stockholm (Sweden)

Dr H. van Zile Hyde, Medical Director, US Public Health Service, Federal Security Agency, Washington, D.C. (United States of America)

Dr M. de Laet, Secrétaire général du Ministère de la Santé publique et de la Famille, Brussels (Netherlands)

Dr M. Mackenzie, Principal Medical Officer, Ministry of Health, London (United Kingdom)

Sir Arcot L. Mudaliar, Vice-Chancellor, University of Madras (India) (*Chairman*)

Dr M. Nazif Bey, Assistant Under-Secretary of State, Ministry of Public Health, Cairo (Egypt)

Dr J. Parisot, Professeur d'Hygiène et de Médecine sociale à l'Université de Nancy (France)

Dr G. H. de Paula Souza, Director and Professor, Faculty of Hygiene and Public Health, University of São Paulo (Brazil)

Dr A. Stampar, President of the Yugoslav Academy of Sciences and Arts, Professor of Public Health and Social Medicine, University of Zagreb (Yugoslavia)

Dr E. Tejera, Former Minister of Health and Social Welfare, Professor of Tropical Pathology, Caracas (Venezuela)

Dr E. Tok, Under-Secretary of State, Ministry of Health and Social Assistance, Ankara (Turkey)

Dr A. Villarama, Secretary (Minister) of Health, Manila (Philippine Republic)

Dr J. Zozaya, Technical Adviser, Ministry of Health and Welfare, Mexico City (Mexico) (*Vice-Chairman*)

The following members were absent:

Dr N. Evstafiev, Deputy Minister of Public Health, Minsk (Byelorussian Soviet Socialist Republic)

Dr N. A. Vinogradov, Deputy Minister of Public Health, Moscow (Union of Soviet Socialist Republics)

The Chinese Government has not yet designated a person to replace Dr W. W. Yung, former Member of the Board.

Health Statistics

The Board implemented a request of the Second Health Assembly by deciding to establish as from 1 January 1950 three small sub-committees of the Expert Committee on Health Statistics [10] One, of a temporary nature will study the definition of stillbirth and abortion Another will determine the proper action to be taken by the committee on hospital statistics giving primary attention to the application of the new *International Statistical Classification of Diseases Injuries and Causes of Death* [11] and related subjects The study of problems concerning the registration of cases of cancer as well as their statistical presentation was allotted to the third sub committee

Requests for Relationship with WHO

By another decision of the Board the Council for the Co ordination of International Congresses of Medical Sciences was brought into official relationship with WHO on the basis of the principles laid down by the First World Health Assembly The Board took a similar decision with regard to the Biometric Society but postponed consideration of requests from a number of other non governmental organizations until its next session

Headquarters Accommodation

The Second Health Assembly had referred to the Executive Board the decision on accommodation for the headquarters office at Geneva in view of the fact that the plans submitted were not sufficiently developed to enable the delegates to take a decision [12]

Since then an entirely new plan has been drawn up by M J Carlu an architect consulted by the Secretary General of the United Nations This envisages various enlargements of the Palais des Nations which would provide for more than 300 new offices a figure above that of present needs and at the same time satisfies the various conditions laid down on the one hand by the United Nations and on the other by the Swiss Government and the Government of the Canton of Geneva The Executive Board accordingly approved it subject to the agreement of the Secretary General and subsequently of the General Assembly of the United Nations The cost of these alterations is estimated at about 4 688 000 Swiss francs The Swiss Federal Council expects to make a financial contribution to the building

[10] *Chron World Hlth Org* 1949 3 199 see also p 51

Supplement 1 to *Bull World Hlth Org* 1948 1949 2 vols This may be obtain d f om the World Health Organization Sales Sect on Palais des Nations Geneva at the pr ce of $6 00 or 30/ p t-free Volume 1 is already a ailable volume 2 (alphabet cal index) will be ava labl shortly

[11] *Chron World Hlth Org* 1949 3 214

established in recent months This development was welcomed not only because of the importance which it has in itself but also because it is certain to have a direct bearing on the work of the WHO committee the national committees are expected to report their findings and recommendations from time to time to the WHO committee for international consideration clearance of national viewpoints and co-ordination with the interested statistical services of other inter governmental organizations [4]

FIG 3 EXPERT COMMITTEE ON HEALTH STATISTICS FIRST SESSION I



Left to right (s ted o d table) D Marie Cakrto a (WHO) Mis L E Bodme D D Cu iel D P F D no D P St cks M ss J E Backe Dr M P scue (WHO) Dr M Kacprzak (Chai ma) B Grab (WHO) P ofessor J Rasuhin Professe r L He sch Dr H L Dunn

Now that several countries had carried out the recommendation to establish national committees the committee felt that WHO should renew its efforts to encourage their formation in other countries The Secretariat was therefore requested to issue a document setting forth the reasons for the establishment of national committees emphasizing their aims suggesting problems which might need solution and reporting on the present status of those national committees already organized [5] The committee made two further recommendations which have been approved in principle by the Second World Health Assembly [6] held in Rome in June 1949 but which cannot be carried out until the necessary financial arrangements have been made One of these was that a special unit with adequate funds for travel and other expenses involved in direct assistance to national

Off R World Hl h Org 11 30 see also *Ch on. World Hl h Org* 1948 2, 115

I f rmatio concerning the establishment of the io al mmittees in various countries will be g ven f rthcomi g mbers of he *Chroni le*

Off R W ld Hl h Org 21 28

IMPROVEMENT OF MEDICAL STATISTICS

First Session of the Expert Committee on Health Statistics

The newly established WHO Expert Committee on Health Statistics at its first session, held in Geneva from 23 to 28 May 1949 [1] instituted further measures which it is hoped will result in the improvement of international health statistics. Most of the time was devoted to the discussion of problems connected with the international comparability of health statistics.

National Committees on Health Statistics

The International Conference for the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death held in Paris in April 1948 [2] had realized that to be truly effective action in medical statistics had to be conducted on both the international and the national planes. This principle was later endorsed by the First World Health Assembly,[3] and it had therefore been recommended that all governments should establish national committees on vital and health statistics to study certain special problems such as medical certification, cancer registration and statistics of malaria morbidity.

The committee had before it evidence that, in several countries including France, the USA and the United Kingdom, national committees had been

[1] The following took part in this session:

Members

Dr D. Curiel, Chief, Division of Epidemiology and Vital Statistics, Ministry of Health and Social Welfare, Caracas, Venezuela

Dr P. F. Denoix, Chef des Services techniques et de la Section du Cancer, Institut national d'Hygiène, Paris, France

Dr H. L. Dunn, Chief, National Office of Vital Statistics (US Public Health Service), Washington, D.C., USA

Dr M. Kaczprzak, Professor of Hygiene, Director, State School of Hygiene, Warsaw, Poland (*Chairman*)

Dr P. Stocks, Chief Medical Statistician, General Register Office of England and Wales, London, United Kingdom

Co-opted Members

Julia E. Backer, Sc.D., Chief, Demographic Section, Central Statistical Office, Oslo, Norway

Professeur L. Hersch, Professeur de Démographie à l'Université de Genève, Switzerland

Professor J. Rasuhin, Professor of Social Medicine, University of Zagreb, Yugoslavia

Representatives of specialized agencies

FAO

Dr J. Latsky, Nutrition Representative in Europe

ILO

Miss L. E. Bodmer, Social Security Section

Dr A. Grut, Chief, Industrial Hygiene Section

Dr M. de Viado, Social Security Section

Secretary

Dr M. Pascua, Chief, Health Statistics Section, WHO

The following were invited to attend as co-opted members but declined:

Professor M. Greenwood, F.R.S., Professor Emeritus of Epidemiology and Vital Statistics, London School of Hygiene and Tropical Medicine, United Kingdom

Professor J. Reed, Chairman, US National Committee on Vital and Health Statistics, Department of Biostatistics, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md., USA

Professor J. Heyman, Radiumhemmet, Stockholm, assisted at the discussion on cancer statistics.

[2] *Chron. World Hlth Org.* 1948, 2, 109

[3] *Off. Rec. World Hlth Org.* 13, 304

publications of WHO It was agreed that there was a need for three periodicals

(1) a weekly containing data on pestilential diseases for quarantine purposes (*Weekly Epidemiological Record*)

(2) a monthly containing provisional data on communicable diseases and vital statistics for the current general information of health administrations (*Epidemiological and Vital Statistics Report*) and

(3) an annual volume of corrected and completed figures on the same subject as in (2) for reference and research [8]

The view of the committee was fully shared by the Second World Health Assembly and WHO will therefore continue to publish the three periodicals

The committee next discussed the inadequacy of the health statistics now published and the immediate possibilities of obtaining further data It was fully aware that the unequal degree of development of the medical and statistical services throughout the world did not always permit of the collection and publication of reliable and therefore comparable health statistics Superficially this may seem to lead to the rather negative conclusion that the collection of statistics should be limited to a few countries The committee dissented however from any such view and emphasized that in its opinion the international publication of such statistics was of value not only to show the seasonal variation and trend of diseases within the countries but as a stimulant to improvement

Classification of available statistical data according to the rules adopted by the First World Health Assembly and published recently as the *Manual of the International Statistical Classification of Diseases Injuries and Causes of Death* (*Bulletin of the World Health Organization* Supplement 1) should result in improved statistics There was evidence however that the application of the *Manual* was not sufficiently understood in every case and the committee therefore recommended that WHO should prepare a short booklet elaborating and illustrating the provisions already made in the *Manual* This recommendation was approved by the Second World Health Assembly and provided suitable financial arrangements can be made the booklet will be supplemented by a clearing centre to be set up within the Secretariat to deal with problems arising in the application of the *Manual*

WHO is expected to stimulate the exchange of information between health administrations with regard to the improvement of medical certification the application of the *Manual* and the training of personnel responsible for statistical work

From 1922 1938 the Health Organization of the League of Nations published an *Annual Epidemiological Report* (containing statistics of notifiable diseases) although this title did not appear each number until 1934. A volume consolidating the figures for 1939 1946 is now in preparation, and will be entitled *Annual Epidemiological and Vital Statistics 1939-1946*. This will be followed by volumes covering the years 1947 and 1948 the latter of which is designed to restore the publication

committees should be set up in the Secretariat to report on the work of national committees and to supply information which might be of value to them The other proposal was that WHO should initiate an international conference early in 1952 of representatives of national committees to be sent at the expense of their own governments to discuss such problems as can best be solved by international co operation

Means of Improving National Statistics

Some time was devoted by the committee to a discussion of the actual means of improving national statistics

It was agreed that the attention of governments should be drawn to the desirability of compiling statistics of infectious diseases on a weekly basis rather than by periods of 10 days or a month as the latter methods do not allow of comparisons and therefore defeat the purpose of the accumulated data

Countries should also be asked to give an estimate of completeness of their mortality figures and of the proportion of deaths the causes of which were adequately certified by physicians Such information is indispensable as in many cases the lack of physicians and proper administrative machinery often results in death certificates being signed by others than medical men or qualified officers Under these circumstances some certificates are bound to carry incorrect diagnoses and it would be of great value if an approximate estimate of their proportion were available

Another suggestion was that countries unable to provide satisfactory statistics for the whole of their territory should supply figures for those towns or areas in which reliable statistics can be compiled Each country would be requested to indicate the estimated degree of incompleteness of the notifications referring to each of the main communicable diseases

Finally the committee expressed the view that the publication of mortality rates for separate causes such as cancer without reference to age or sex did not give a true picture It therefore recommended that WHO publish regularly if not necessarily every year figures of mortality by age and sex for the more important diseases together with corresponding population figures for countries selected for the accuracy of their statistics [1]

Comparability of International Statistics

Turning to international statistics and more specifically to the vexed problem of their comparability the expert committee began by making a brief survey of the adequacy of the present epidemiological statistical

[1] The report of the committee from which this and other extracts appearing in this article are taken will be published shortly

knowledge of statistical methods to such an extent that Professor M Green wood felt it necessary to warn the committee that there is a great danger that the medical officer the doctor of medicine will either despise the mere mathematician who knows nothing of smallpox but its name or over-estimate the value of conclusions supported by mathematical arguments on the principle *omne ignotum pro magnifico*

The committee devoted a great deal of time to this subject and it was finally agreed to emphasize the importance of the teaching of medical recording procedure and elementary statistical methodology to all medical students preferably in the second and third years of their training. The committee also advocated the teaching of more advanced statistical methodology and vital statistics to medical and other graduates who are training for public health posts Instruction in the background of medical statistics should be systematically given to non medical persons engaged in medical coding the keeping of records and preparing statistics in public health offices hospitals and social security institutions

With the adoption of these recommendations an important step was made in the direction of improved medical statistics It now rests with the universities in various countries to consider the proposals of the WHO committee and to carry them out

New Statistical Studies

A recommendation by the committee which was approved by the Second World Health Assembly and which may have far reaching con sequences was that new international bodies should be established to study (*a*) cancer statistics (*b*) hospital statistics and (*c*) definition of still birth and abortion It has long been recognized that neither the cancer statistics nor the hospital statistics of the various countries are entirely satisfactory Furthermore it is urgently necessary to fix the limits between live birth and stillbirth and between stillbirth and abortion in order to obtain an international definition of stillbirth [9] Three expert sub-committees will be set up to study these problems and report to the Expert Committee on Health Statistics The sub-committee entrusted with the study of cancer statistics is also expected to investigate the question of the modifications to be made in the presentation of possible future editions of the *Annual Report on the Results of Radiotherapy in Cancer of the Uterine Cervix* [10] The fifth volume was recently published in Stockholm under the joint auspices of the British Empire Cancer Campaign London the Donner Foundation Philadelphia the Cancerföreningen Stockholm and the World Health Organization

See Pascua, M (1948) *Epidem. Vital Stat. Rep.* 1 210
Chron. World Hlth Org. 1948 2, 32

Health Statistics in Underdeveloped Areas

It is well known that the proper assessment of health in underdeveloped areas is difficult The committee considered the present obstacles and discussed the need for evaluating the effectiveness of projects to improve health and nutrition in such countries At the recommendation of the committee, studies will be carried out in underdeveloped areas of available methods of measuring the state of health of populations and the prevalence of diseases These studies will aim at the improvement of the present methods of work and will probably be initiated by conferences within the region concerned in which local specialists and one or more members of the WHO Secretariat will participate The Second World Health Assembly approved in principle the convening of three such conferences to be financed by a sum of money from the supplemental budget The committee also considered it desirable that when projects aiming to improve health conditions of underdeveloped areas are initiated proper arrangements be made in advance by the competent statistical advisory committees of the international agencies concerned to collect such vital statistics as may be possible throughout the period of the work with a view to assessing the improvement in health which actually results from carrying out the projects

FIG 4 EXPERT COMMITTEE ON HEALTH STATISTICS FIRST SESSION II

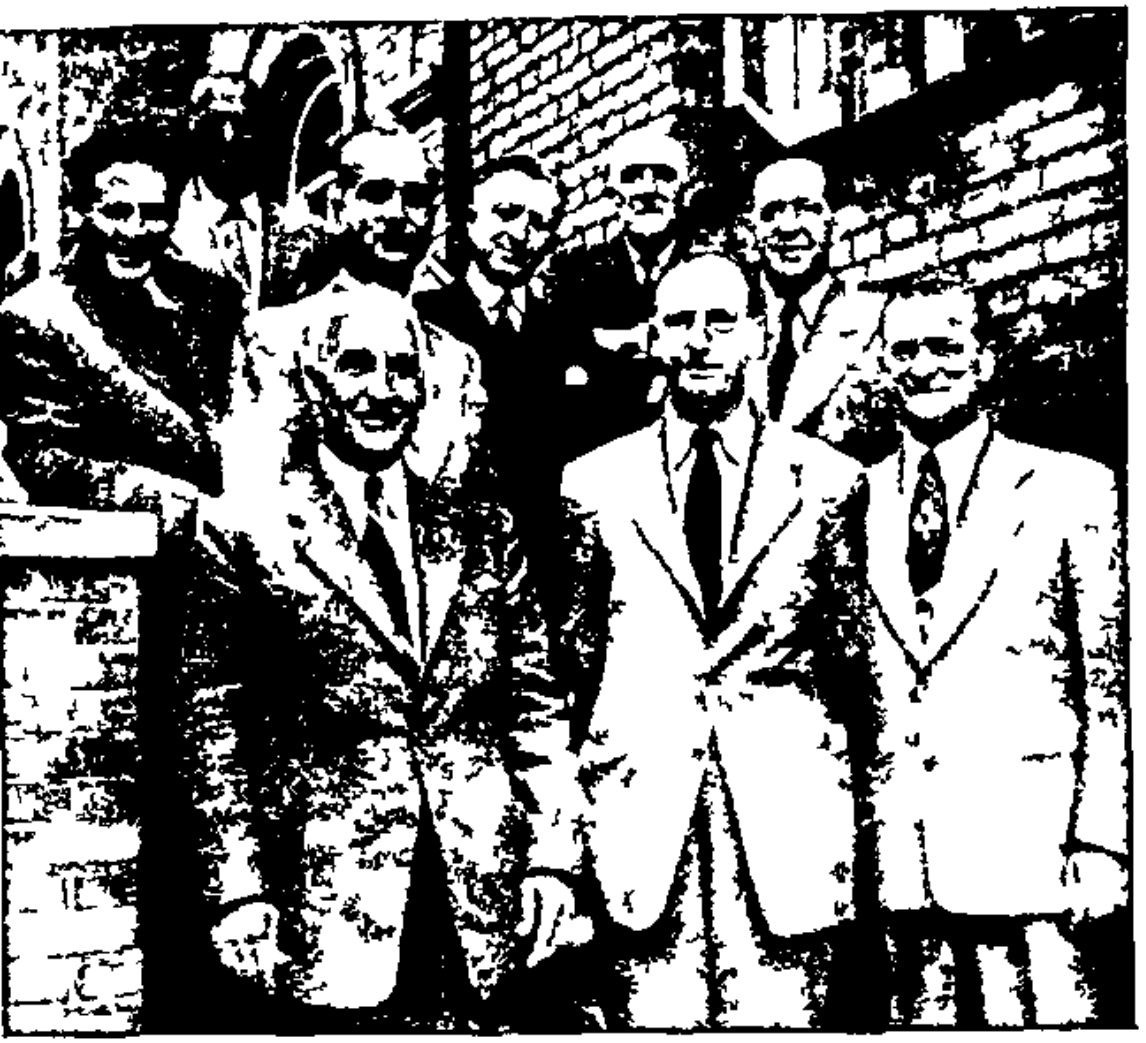


Left to right Dr M Pascua (WHO) Dr M Kacprzak (Chairman) B Grab (WHO)

Teaching of Health Statistics

One of the most urgent problems before the committee was that of the training of health statistics personnel and the teaching of health statistics The responsibility of indicating on the death certificates the underlying cause of death i e the disease or injury which initiated the sequence of morbid events leading to death is placed on the physician and unless he is fully aware of what is expected of him the statistical data collected are bound to remain of doubtful value The number of medically qualified statisticians is notoriously small most medical men lack elementary

FIG 5 EXPERT COMMITTEE ON TUBERCULOSIS FOURTH SESSION



Front, left to right: Dr M. S. Abdel Bey, Dr P. M. de Alarcon Hart, Dr H. E. Hilleboe
Back, left to right: Dr I. Gonda, Dr P. V. Benjamin, Dr J. I. Baldó, Dr E. Bernard, Dr J. B. McDougall (WHO), Dr J. H. Holm (Chairman)

to enable their holders to attend these staff training courses study abroad should be reserved for older Fellows already having professional experience

Demonstration Teams

The teams sent by WHO should work in close co-operation with these suggested training centres In the opinion of the committee it will be necessary to send at least one demonstration team to each region during coming years and if possible during 1949/50

Hospital Buildings

Certain countries have not the necessary resources for the construction of spacious buildings equipped according to modern techniques for the hospitalization of tuberculous patients However as stressed in preceding

TUBERCULOSIS

Fourth Session of the Expert Committee [1]

Among the subjects considered by the Expert Committee on Tuberculosis at the fourth session, held in Copenhagen from 26 to 30 July 1949, were the training of specialized personnel, the construction of hospital establishments for the treatment of the tuberculous co ordination of the work of the international organizations concerned with tuberculosis control and the report of the WHO Research Office on Tuberculosis at Copenhagen

Training of Personnel

An intensive campaign against tuberculosis necessitates a specialized staff composed of physicians nurses and laboratory and X ray technicians However, in most countries the number of such staff is inadequate In certain cases the success of tuberculosis control is even endangered by this lack of qualified personnel despite the best intentions of the governments concerned Thus the committee felt that WHO should collaborate in the setting up of permanent centres for the training of personnel in all branches of anti tuberculosis work Doctors nurses and technicians should as far as possible, be trained in the same regional centre which should therefore possess a dispensary, a laboratory, an epidemiological division a mobile X ray unit and treatment facilities One or more of these centres should be set up in each WHO region i e the group of territories making up a regional organization Furthermore WHO could contribute to the efficient working of these centres on the one hand by seconding instructors and on the other hand by awarding fellowships to the trainees The committee considered that the fellowships awarded should be used mainly

The complete text of the report on the fourth session of the Expert Committee on Tuberculosis will be published after approval by the Executive Board

[1] *This session was the first of the enlarged committee which will consist of nine members (the ninth member has not yet been appointed)* The following took part in these meetings

Members

Dr M S Abaza Bey Adviser Misr Weaving & Spinning Co Cairo Egypt
Dr J I Baldó Chief Tuberculosis Division Ministry of Public Health Caracas Venezuela
Dr P V Benjamin Tuberculosis Adviser Directorate General of Health Services New Delhi India
Dr E Bernard Professeur à la Faculté de Médecine de l Université de Paris France (*Vice Chairman*)
Dr I Gonda Chief Tuberculosis Control Division Department of Public Health for Slovakia Bratislava Czechoslovakia
Dr P M D Arcy Hart Director Tuberculosis Research Unit National Institute for Medical Research (Medical Research Council) London United Kingdom (*Rapporteur*)
Dr H E Hilleboe Commissioner of Health New York State Department of Health Albany N Y USA
Dr J H Holm Chief Tuberculosis Division State Serum Institute Copenhagen Denmark (*Chairman*)

Co-opted members

Dr Bretey Chef du Service de la Tuberculose à l Institut Pasteur Paris France (Member of the Tuberculin Testing and BCG Vaccination Panel WHO)
Dr F R G Heaf *Adviser in Tuberculosis Ministry of Health (England and Wales)* and Department of Health for Scotland London United Kingdom (Member of the Tuberculin Testing and BCG Vaccination Panel WHO)

Secretary

Dr J B McDougall Chief Tuberculosis Section WHO

The vaccination campaign undertaken by the Joint Enterprise is developing rapidly at the end of May 1949 13 000,000 persons had been tested with tuberculin and 6 000 000 had been vaccinated in Austria Czechoslovakia Finland Greece Hungary Italy Poland and Yugoslavia The campaign has also started in Ceylon India and North Africa plans are ready for its extension to Pakistan and the Middle East and it is probable that it will soon start in the Far East and in Latin America

The first statistical results of the vaccination campaign in Poland were laid before the committee These data which relate to provinces where the campaign has been completed show the number and sex of persons tuberculin tested the percentage according to sex and age of persons giving a positive reaction and the total number of persons vaccinated At the end of May 1949 more than 3 700 000 persons had undergone the tuberculin test and more than 1 700 000 had been vaccinated Thanks to the co operation of both the Polish and Scandinavian staff school children readily lent themselves as subjects for vaccination In one province they represented 62 % of the total number undergoing the tuberculin test It was observed that the percentage of children giving a positive reaction increased with age as follows 30% at 7 years of age 40 % at 10 years of age and 65 % at 15 years of age

The information on tuberculin sensitivity which has now been collected in many countries and in areas which are widely separated from one another will be of great value from the epidemiological point of view It will permit detailed comparison of the degrees of tuberculin sensitivity according to countries and to the various regions of the same country In countries where morbidity and mortality statistics are non-existent these data will be the only ones from which an idea of the prevalence of tuberculosis can be obtained and consequently they will be very useful in the drawing up of tuberculosis-control programmes

The committee approved the programme of the WHO Tuberculosis Research Office and suggested that the terms of reference of this office should be enlarged to include all public health aspects of tuberculosis particularly those in which WHO has commitments it expressed the wish that the office should be in contact with the national organizations dealing with the same subjects that it should seek to stimulate their research and finally that it might train workers in the epidemiology of tuberculosis

Other Matters

The question of attaching a tuberculosis specialist to each regional organization which was submitted to the Second World Health Assembly and to the Executive Board [4] was examined by the committee which repeated its recommendations to this effect

Ch W H O Off Rec 1949 3 190

reports this is precisely one of the essential elements in the success of the campaign With the aim of permitting these States to obtain under advantageous conditions facilities for the isolation and treatment of patients WHO contacted a certain number of firms in different countries asking them to submit plans and estimates for the supply of portable wooden or metal buildings which could be easily transported by land or water Each of these buildings would be designed to provide at least 20 beds they would include premises for laboratory examinations and in certain cases quarters for the nursing personnel The Secretariat has received numerous projects which have been examined by the committee A report on this subject will appear later

Relations with Other Organizations

In view of the large amount of work to be accomplished in many countries the co ordination of all activities appears necessary, whether those of inter governmental institutions such as WHO and the Joint Enterprise (UNICEF, the Danish Red Cross and its Scandinavian associates with the technical help of WHO), or of voluntary non governmental organizations such as the International Union against Tuberculosis and the League of Red Cross Societies which includes 68 national branches The last two organizations have expressed the wish to work in conjunction with WHO , their representatives explained their respective plans and programmes to the committee The committee thanked these organizations for their offers of collaboration it also recommended that WHO through its field staff, should encourage the establishment of voluntary antituberculosis associations in countries where they do not so far exist, as well as their affiliation to the International Union against Tuberculosis

As regards the Joint Enterprise the committee felt that the needs of many countries were so great that its action should be extended to those sectors of tuberculosis control where WHO because of lack of funds and personnel cannot operate

In order to co ordinate these different activities and to make the best use of the resources at the disposal of the four organizations mentioned the committee proposed that representatives of each of them should meet from time to time in order to discuss problems of common interest

WHO Tuberculosis Research Office

The work in progress and the lines which it is following were explained to the committee by the Director of the Office Some of this information communicated to the Joint Committee on Health Policy UNICEF/WHO has been published in a previous number of the *Chronicle* [3]

[3] *Chron World Hlth Org* 1949 3 77

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Other Matters

The question of attaching a tuberculosis specialist to each regional organization which was submitted to the Second World Health Assembly and to the Executive Board [5] *was examined by the committee which repeated its recommendations to this effect*

[5] *Chron World Hlth Org* 1949 3 190

The committee again stressed the dangers presented by an unduly large distribution and indiscriminate use of streptomycin as well as by the development of resistant strains of bacilli resulting therefrom It also took note of a letter on this subject sent by WHO to the governments in April 1949

The committee examined the observations of the Executive Board with regard to the report on the third session of the Expert Committee on Tuberculosis and after having reconsidered the document revised certain parts of the annex relating to Suggestions for the Control of Tuberculosis in Countries with Undeveloped Programmes [5]

[5] *Off Rec World Hlth Org* 15 16 *Chron World Hlth Org* 1948 2 239

MALARIA

The report on the third session of the Expert Committee on Malaria[1]*—held in Geneva from 10 to 17 August 1949—which will be published after approval by the Executive Board deals with various topical aspects of the malaria problem including malaria in underdeveloped countries antimalarial drugs the use of insecticides and the activities of WHO with regard to malaria The following pages give a survey of the work of this session and information on some of the subjects on the agenda*

Antimalarial Drugs

The chemotherapy of malaria which up to recent years played an important part in the control of this disease has been relegated to second place by the discovery of insecticides with a residual effect Even if chemotherapy is now only an auxiliary means of defence however it still retains its importance as an emergency measure in the event of epidemics Furthermore, in countries where insect control is not yet organized it is often

[1] The following were present at this session

Members

Colonel M K Afridi Director Malaria Institute of Pakistan and Bureau of Laboratories Karachi Pakistan

Major General Sir Gordon Covell Adviser on Malaria Ministry of Health Director Malaria Laboratory Horton Hospital Epsom Surrey United Kingdom (*Vice Chairman*)

Dr A Gabaldón Chief Division of Malariology Ministry of Health and Social Welfare Maracay Venezuela

Dr P F Russell Malaria Adviser International Health Division Rockefeller Foundation New York USA (*Chairman*)

Lieutenant-Colonel J Singh Director Malaria Institute of India Additional Deputy Director General of Health Services New Delhi India

Professor N H Swellengrebel Director Institute for Tropical Hygiene Amsterdam Netherlands

[*Continued on p 257*]

necessary to resort to chemotherapeutic agents for the rapid treatment of a large number of patients

The results obtained with synthetic drugs during and after the war have been conclusive enough to enable the committee to give in the course of the second session [3] details suitable for the purposes of physicians in all countries concerning the action and dosage of the most important of these substances including mepacrine (atabrine) proguanil (paludrine) chloroquine pamaquine (plasmoquine) and many of their derivatives Recent research and experimental work has led the committee during the third session to develop and define more closely some of its former conclusions as well as presenting new ones

Treatments employing on the one hand quinine and on the other hand the new synthetic drugs particularly mepacrine have shown that quinine is less active than these drugs and may be advantageously replaced by some of them In a general way as stressed by the committee none of the antimalarial drugs known today satisfies the requirements for an ideal drug which should be both a causal prophylactic against all species of malarial haematozoa and a good therapeutic agent making possible not only the clinical cure of the disease but also the radical cure of the infection [3] Furthermore it should be either nontoxic or only slightly so readily available and moderate in price

The committee felt obliged to emphasize furthermore that it is not sufficient to formulate general rules for the use of these drugs since their activity may be modified by different factors such as the sensitivity of the different strains of parasites and the degree of immunity of the popu lation The cost is also important in the choice of drugs intended for mass chemotherapy The problem of the regional production of drugs is closely linked with this question The committee felt it desirable that such production should be encouraged and that through the intermediary of the

C inued from p 256

Médecin-Général I pecteu M A V ucel D recteu d Service d S té col ial, Minis re de la France d Outre-M P ris F nce

D D B Wilson Director East Africa Malaria U t, M heza, Tang yika

Co-op d m mbe

D G R C ney Ch f Sec f Chemotherapy of Pr tozoological Diseases, Microbiological Ins N al Ins t tes f Health (US P blic H alth Service) Bethesda Md USA

Professo G Macdonald Directo Ross Instit te of Tropical Hygiene London School of Hygiene and Tropical Med cine Uni ed Ki gdom

Professo A Mis li Chief P ras tology Dep rtmen I tituto S perio d San tà R me I aly

FAO prese re

F L M Do g ll Counsell

Secr ar

D E J Pamp a, Chief Mal ria Section WHO

Chron World Hl h O g 1948 2 147

Th definitions of some f the terms sed in his articl re as f llows

S ppress re tmen th dministration f drugs w th the aim of ppres ing the linical symp oms of malaria w thout preventing the infection.

C usal prophylaxis th dm nistratio f drug w h th im f prev g he infect n f h eryth ocytes by malari l paras tes. It in lves an actio f th drug either th porozo tes or the pre-erythrocytic tages f the haematozoon.

Cl ical c re he re f th clinical ymptoms b t not ecessarily of the infecti

R dical cure the ra ical of the infecti any te th bsence f subseq en l pses, the clinical r paras tic — Ed

international economic agencies WHO should make an inquiry into the possibilities of manufacture on a regional scale These possibilities would clearly depend on the availability of raw materials and on local technical factors

In the light of recent experience it seems preferable to provide for the manufacture of synthetic drugs rather than to develop the cultivation of cinchona, which would take up acreage which could be employed for other purposes Generally speaking it seems that quinine will be gradually replaced by the synthetic drugs which as will be shown have many advantages over it

Quinine Quinine is usually thought of as being closely connected with the treatment of malaria and consequently the drug still retains a high reputation though the new synthetic compounds are unquestionably more active Moreover a marked reduction in the incidence of blackwater

FIG 6 EXPERT COMMITTEE ON MALARIA THIRD SESSION I



fever was recorded on replacing quinine by mepacrine in the prophylaxis and treatment of falciparum malaria among British troops stationed in West Africa during the second World War

Mepacrine (atabrine) Mepacrine which was employed as a substitute for quinine, has shown itself to be an excellent antimalarial The drug settles in the tissues which gradually liberate it into the blood plasma and its effectiveness is a function of its concentration in the plasma These facts led to the adoption of a regimen of large loading doses during the

first day or first two days of therapy to obtain prompt action Owing to the slow release of mepacrine from the tissues into the plasma a sufficient concentration is maintained long enough to ensure a suppressive effect and to delay relapses from five to seven weeks On the other hand mepacrine has no causal prophylactic effect Its main advantages over quinine are that it can be rapidly manufactured in large quantities that it is a very effective therapeutic and suppressive agent and that, because of its slow elimination its use increases the intervals between relapses in benign tertian and probably also in quartan malaria

Chloroquine and other 4-aminoquinolines Chloroquine has advantages which from the clinical viewpoint are even greater than those of mepacrine Like the latter it settles in the tissues which liberate it slowly into the blood where it maintains a sufficient concentration to delay relapses even longer than does mepacrine It makes clinical cure possible after very brief treatment which in certain cases may even be limited to the administration of a single dose and generally results in the radical cure of falciparum infections As a suppressant administered once weekly it has an action superior to that of the other antimalarials against all strains of malaria parasites studied so far On the other hand it has the disadvantage of having a smaller margin of safety than that of proguanil and of being rather expensive The other 4-aminoquinolines (sontochin and oxychloroquine for example) do not appear to be superior to chloroquine

Proguanil (paludrine) The exceptional properties of proguanil led to its being originally considered as the ideal antimalarial Subsequently however it was found that it had certain defects capable of seriously limiting its use It is definitely superior to all other antimalarial drugs thanks to the wide range separating the minimum effective dose from the maximum tolerated dose Thus doses of 6 to 12 mg daily of proguanil (base) have been found effective while 1 4 g of proguanil per day have been given for 28 days without ill effects Unlike quinine mepacrine and chloroquine proguanil exerts a causal prophylactic action against *P falciparum* It can be employed as a therapeutic agent against all forms of malaria but its action is less rapid than that of the drugs previously mentioned and it is not suitable for the emergency treatment of severe cases Furthermore certain strains of *P falciparum* have shown themselves resistant to the drug. This could probably be overcome by reinforcing proguanil with mepacrine at the commencement of treatment

Pamaquin (plasmoquin) and other 8-aminoquinolines The compounds which have just been described are drugs which have only an alleviative or suppressive effect in the case of vivax infections and cannot ensure radical cure On the other hand the 8 aminoquinolines have the advantage when associated with quinine of ensuring the radical cure of these infections This fact is of great importance in the case of patients who are not likely

to be re exposed to infection The 8 aminoquinolines are also distinguished from the other groups of antimalarial drugs by another property namely that they are capable of producing causal prophylaxis against all forms of malaria and are excellent gametocides However, they are hardly of practical value in either of these fields since their causal prophylactic effect does not appear except in dosages which are too close to the toxic level and their gametocidal properties do not materially affect the transmission of malaria within a community The various compounds within the group differ from one another in their degree of toxicity primaquin being the most toxic followed by pentaquine and isopentaquine in that order

Indications

From the point of view of the chemotherapeutic treatment of malaria the following indications may be given for the drugs discussed above

Treatment of a clinical attack Quinine mepacrine chloroquine (and the other 4 aminoquinolines) or proguanil when given in suitable doses will nearly always overcome acute attacks of malaria The choice and dosage of drug depend on various factors such as rapidity of action side effects, length of treatment nature of the relapse pattern in vivax infections, natural or acquired strain resistance the degree of immunity of the population cost of the drug and quantity available Chloroquine and proguanil satisfy these various requirements best and may be considered as the drugs of choice for routine therapy but proguanil is not to be recommended for emergency use in serious cases

Treatment for the radical cure of vivax malaria In relapsing vivax malaria concurrent treatment with quinine and an 8 aminoquinoline offers an excellent chance of radical cure The same results may be obtained by the prolonged administration of weekly doses of proguanil using the dosage specified for suppressive treatment

Suppressive treatment When given at appropriate intervals all the preceding drugs with the exception of the 8 aminoquinolines will keep malaria latent under normal conditions of exposure or following treatment of an acute attack Chloroquine and proguanil have proved effective suppressants in the majority of countries and are the most convenient to use because of their large margin of safety Quinine is the least effective drug [4]

The committee proposed that some of these drugs be included in the *Pharmacopoeia Internationalis*

Field and hospital trials of suppressive treatment The committee felt that WHO should concentrate its efforts in this matter towards stimulating

[4] Details concerning the dosages of these various drugs are given in the report of the committee

and co-ordinating therapeutic experiments with antimalarials in different institutions and in different countries rather than undertake such experiments on its own initiative However WHO should offer its good offices for the direction of these trials and inquiries so that the results obtained in different countries will be comparable The results of these investigations should be sent by the institutions direct to WHO which will be responsible for analysing them [5]

Control of the Adult Insects versus Eradication of the Vector Species

The eradication i e the absolute elimination of the vector species of malaria which is in process of realization in Sardinia and Cyprus has given rise to the hope that this radical form of malaria control might come into general use The committee discussed this question in detail and examined for the health authorities the respective merits of the two methods on the one hand the control of anophelines by insecticides with a residual action and on the other the eradication within a given area of malaria carrying species of mosquito a method essentially involving larval control While fully realizing the considerable advantages obtained by the eradication of the vector species the committee drew the attention of the authorities concerned to the fact that the success of measures with this aim depends on a number of factors the presence or absence of natural barriers e g mountains which might impede the reintroduction of anophelines local topography which may be favourable or otherwise for the formation of breeding places and the economic state of the country This last point is important since eradication is costly it may entail clearing and drainage and must be undertaken over the whole of a territory which necessitates detailed organization and qualified personnel Furthermore preliminary investigation of the habits of the vector species is necessary in order that the campaign may be rationally conducted In addition when an area is freed from certain species of mosquito a vigilant watch must be kept to prevent their reintroduction

Malaria control by the spraying of residual insecticides has the advantage of stopping the transmission of malaria in a simple and direct way It may be limited to houses and shelters in malarious areas and does not entail a preliminary study of the bionomics of the parasites Spraying with insecticides has the secondary effect of destroying other harmful insects Finally from the administrative viewpoint control by means of insecticides may be decentralized to a large extent although it would appear desirable for it to be organized on a countrywide scale This method gives rapid results and in particular makes it possible to prevent an epidemic or to check its spread

[5] Details of the organization of these investigations are given in the report of the committee.

The advantages and disadvantages of the two methods should be taken into consideration by authorities who wish to draw up a malaria control programme In stressing this fact the committee recommended

FIG 7 EXPERT COMMITTEE ON MALARIA THIRD SESSION II



Left to right Major General Sir Gordon Covell (Vice-Chairman) Dr P F Russell (Chairman) Dr E J Pampana (WHO)

that neither of the methods in question be applied over the whole of a territory without preliminary trials in a limited area in order to estimate the chances of success and the cost involved

Measures against the Reintroduction of Anophelines

The question of the measures to be taken in order to prevent the re introduction of anophelines into areas which have either been freed from them or are naturally free from vector species was already broached by the committee during its second session [6] and was subsequently examined in detail by the Expert Committee on Insecticides [7] Whatever measures may be prescribed for the disinsectization of ships and aircraft, rigid control of anophelines should be carried out in the immediate neighbourhood of sea and airports with the especial object of eliminating all potential breeding places for accidentally imported mosquitos The Expert Committee on Malaria considers that this is the best safeguard against the re introduction of anophelines

[6] *Off Rec World Hlth Org* 11 56 *Chron World Hlth Org* 1948 2 151
[7] *Chron World Hlth Org* 1949 3 136

Collaboration of WHO with Other Organizations

The committee noted with satisfaction the resolutions of the Second World Health Assembly concerning activities undertaken jointly with other international organizations in malaria control The United Nations Economic and Social Council has adopted resolutions aiming at making it easier for non producing countries to acquire insecticides and antimalarial materials the United Nations International Children s Emergency Fund (UNICEF) is carrying out antimalarial campaigns in East Asia with the co-operation of WHO and of the various governments the Food and Agriculture Organization (FAO) is collaborating in a joint project whose long term consequences will be of the utmost importance

Joint FAO/WHO project The project for joint FAO/WHO co-operation for combating malaria and increasing the production of foodstuffs in areas selected for this purpose was discussed by the committee at its second session and approved by the Second World Health Assembly[8] After again considering the matter during its third session the committee suggested that lists of areas complying with the requisite conditions be drawn up by both FAO and WHO that these lists be combined and that a maximum of three areas of a size suitable to the aim in view be finally selected The committee further proposed that the governments make known through the regional offices of WHO the areas in which they would be prepared to collaborate in the joint work The FAO representative expressed the view that priority should be given to areas in Latin America the Near East and Asia

Draft Recommendations to Governments

The First Health Assembly formulated recommendations to be sent to the governments of Member States on the legislative and technical measures necessitated by the control of tuberculosis and venereal diseases as well as by maternal and child health[9] The recommendations concerning malaria one of the four subjects given priority by WHO had been deferred in view of the complexity of the technical problems particularly of those relating to a choice between control of adult mosquitos and larvicidal methods the Assembly had entrusted the Executive Board with the task of formulating them The latter referred the question to the Expert Com mittee on Malaria which after examining it during its third session has drawn up a draft for submission to the Executive Board

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BIOLOGICAL UNIT OF ACTIVITY

Its Status and Scope

The concept of a biological unit arose from the need to measure and find some means of expressing the activity of biological substances such as sera, vitamins, hormones and antibiotics whose chemical constitution was not precisely known or which were heterogeneous in nature so that no *constant relation between weight and activity could be established*

The concept was first applied by Ehrlich at the end of the last century to the standardization of diphtheria antitoxin and since then standard units have been set up for many biological substances The task of fixing internationally recognized units of activity by the critical comparison of results obtained in laboratories in various countries was first carried out by the Permanent Commission on Biological Standardization of the League of Nations Health Organization, and today this work is being performed by the Expert Committee on Biological Standardization of the World Health Organization During the last twenty five years units have been defined and standards established in this way for more than thirty sub stances including sera—antidiphtheria and antitetanus among others—tuberculin digitalis, ouabain insulin, the arsenobenzenes certain hormones certain vitamins heparin penicillin and streptomycin

A critical study of the concept of biological units and of certain problems at present arising in their use is given in an article by Dr A A Miles Director of the Department of Biological Standards of the National Institute *for Medical Research London and a member of the* WHO Expert Com mittee on Biological Standardization, in the *Bulletin of the World Health Organization*[1] After recalling the stages which led to the setting up of the first unit that for diphtheria antitoxin now a classical example the author examines the value of the animal unit a term frequently and incorrectly used instead of the expression *the range of minimal effective* doses in a given animal It is in fact impossible by comparing the reactions of living organisms to the injection of active substances to obtain results sufficiently constant and lying between narrow enough limits to serve as a basis for setting up internationally recognized units The use of the term animal units , which is even frequently abridged to *unit* without indicating the species of animal used should be abandoned

After considering the conditions which should be satisfied by the concept of a unit if the latter is to be valid Dr Miles next considers the question of heterogeneous standards and the last part of his article is devoted to a study of the problems involved in discarding the unit notation when biological substances originally of a crude or heterogeneous nature have been finally purified and characterized by the chemist and physicist

[1] *Bull World Hlth Org* 1949 2 05

This is the case with vitamin C and vitamin B_1 whose chemical constitution is now known and which are easy to assay without the need for biological tests

With other substances however there is a borderline stage where the standard is no longer necessary in the sense that it is theoretically possible to predict biological activity from the results of a chemical examination but where the standard is retained because biological assay is cheaper and easier In such cases there may be some advantage in designating potency not in units but in weight-equivalents This weight equivalent method has been adopted in the USA for preparations of streptomycin while in the United Kingdom on the other hand the unit notation for this substance is retained The author discusses this example explaining why in the United Kingdom the unit notation is preferred In his opinion the expression of activity by the weight-equivalent method can be of real value only if the standard preparation is pure and homogeneous and if it can be assumed that all subsequent standards intended to replace the master standard will be of the same degree of purity

As regards streptomycin the problem of the relative values of the unit and the weight-equivalent is not only of purely practical interest A question of principle which may have important consequences is involved A national or international standard is an essential part of official definitions in pharmacopoeias and government regulations which are either law or are used as a basis for legal proceedings and commercial transactions It is therefore important to make sure that the official unit is precisely defined so as to avoid any confusion or misunderstanding For example to the organic chemist streptomycin is a base with a structural formula corresponding to N methyl *l* glucosaminido streptosido-streptidine This is not the streptomycin of the pharmacopoeia which means each of several antibiotic substances produced by the growth of *Streptomyces griseus* that is to say that the different substances all bearing this name are far from being identical and that weight by weight they will not have the same biological activity The concept of a unit on the other hand refers to the activity of a standard preparation and not to a hypothetical pure substance

The importance of the problems inherent in a premature discarding of the unit system is therefore evident There can be no doubt that such problems will frequently arise in the future as more and more substances with biological activity are first chemically defined and then synthesized According to Dr Miles unit notation will become superfluous only when biological assay ceases to be indispensable for the specification of materials prepared routinely and when chemical and physical tests alone are sufficient to predict biological activity

the close of the International Health Conference in 1946 From 1950 onwards it will be observed on 7 April—the date upon which that Constitution officially entered into force in 1948

Seminar on World Health

An international Seminar on World Health arranged by the World Federation of United Nations Associations (WFUNA)—an organization which has entered into official relationship with the World Health Organization—took place in Rome during the latter half of the Second World Health Assembly Twenty seven medical students and young doctors from nine countries attended In most cases expenses were met by the participants themselves though a minority travelled on government grants while over 50 applicants were unable to attend owing to lack of funds

The programme of the seminar was arranged so as to allow participants to attend plenary and committee meetings of the Health Assembly Thus an opportunity was provided for these young medical men not only to become acquainted with the purposes of WHO and the details of its programme but also to gain some understanding of the practical problems with which the Organization is faced in carrying out its aims

The lecture programme with specialists prominent in the medical and public health world at the rostrum included The Fight against Tuberculosis by Dr J Holm of the State Serum Institute Copenhagen Heart Diseases by Dr V Puddu of the Cardiac Disease Centre Rome Science Medicine and Unesco" by Dr Irina M Zhukova of UNESCO Economic Development and Health Problems by Dr H van Zile Hyde of the US Public Health Service New Perspectives in Public Health by Dr A Stampar President of the Yugoslav Academy of Sciences and Arts Work of the Institut Pasteur by Professor A R Dujarric de la Rivière Sous Directeur de l Institut Pasteur Paris and Problems of Mental Health by Dr R H Felix of the US Public Health Service Addresses on health problems were also delivered by various other personalities attending the Health Assembly From these lectures and the discussions which followed them the participants were able to gain a conception of public health on a worldwide scale from conversations with delegates many of whom share personally in the medical programmes sponsored by WHO and with observers from specialized non governmental organizations they were able to obtain first hand information on scientific developments in all parts of the world

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